VOLUME 12 • JUNE 1957 • NUMBER VI

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

Library of Boston University
School of Medicine
80 E. Concord St.,
Boston, Mass.

Official Publication of
AMERICAN MEDICAL WOMEN'S ASSOCIATION INC. 1915

LIBRARY
JUL 25 1957
BOSTON UNIVERSITY
SCHOOL OF MEDICINE

In Angina Pectoris
More Comprehensive Action
Pentoxylon®

The patient with angina pectoris requires the comprehensive approach provided by the several actions of Pentoxylon. Each tablet combines the valuable *tranquilizing*, *fear-relieving*, *bradycrotic*, and *nonsoporific sedative* actions of Rauwiloid® (alseroxylon, 0.5 mg.), with the *long-lasting coronary vasodilating* effect of pentaerythritol tetranitrate (PETN, 10 mg.).

- **Reduces incidence and severity of attacks**
- **Increases exercise tolerance**
- **Reduces tachycardia**
- **Reduces anxiety, allays apprehension**
- **Reduces nitroglycerin need**
- **Lowers blood pressure only in hypertensives**
- **Produces demonstrable ECG improvement**

Dosage: one to two tablets q.i.d., before meals and on retiring

P.S. to stop the acute attack faster

Medihaler-Nitro™, the new self-propelled, measured-dose inhalation method delivers 1% octyl nitrite for instantaneous relief of acute anginal pain.

Riker LOS ANGELES

eliminate pain...while maintaining muscle relaxation and patient cooperation . . . **in obstetrical delivery**

Saddle block with Heavy Solution Nupercaine, testified safe by hundreds of thousands of successful deliveries, fulfills the criteria for ideal obstetrical anesthesia: "*1. An anesthetic that is safe for both mother and baby. 2. An anesthetic that is easy to administer, and one in which personnel can be quickly and easily trained. 3. An anesthetic which alleviates pain of delivery for the patient while still inducing complete relaxation for the benefit of the obstetrician.*"[1]

1. Seegar, J.K.B.E., and Devlin, A.J.: Maryland M.J. *5*:330 (June) 1956.

Supplied: 1:400 Nupercaine hydrochloride in 5% dextrose, 2-ml. ampuls, each ml. containing 2.5 mg. Nupercaine and 50 mg. dextrose; cartons of 10.

HEAVY SOLUTION **Nupercaine®**
hydrochloride
(dibucaine hydrochloride with dextrose 5% CIBA)

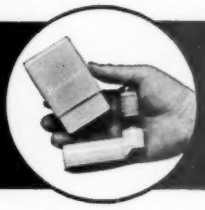
CIBA
SUMMIT, N. J.

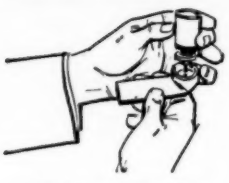
2/2379MB

MILLIONS OF ASTHMATIC ATTACKS

have been aborted faster...more effectively... more economically with

Medihaler®





SIMPLE TO USE

CONVENIENT

SUITABLE FOR CHILDREN, TOO

SLIPS INTO POCKET OR PURSE

Automatically measured dosage and true nebulization...nothing to pour or measure...One inhalation usually gives prompt relief of acute or recurring asthmatic attacks.

Medihaler-Epi replaces injected epinephrine in urticaria, edema of glottis, etc. due to acute food, drug or pollen reactions...Each 10 cc. bottle delivers 200 inhalations.

IN ASTHMA PRESCRIBE EITHER

Medihaler-EPI® Riker brand epinephrine U.S.P. 0.5% solution in inert, nontoxic aerosol vehicle. Each measured dose 0.12 mg. epinephrine. In 10 cc. bottle with measured-dose valve.

Medihaler-ISO® Riker brand isoproterenol HCl 0.25% solution in inert, nontoxic aerosol vehicle. Each measured dose 0.06 mg. isoproterenol. In 10 cc. bottle with measured-dose valve.

Note: First prescription for Medihaler medications should include the desired medication and Medihaler Oral Adapter (supplied with pocket-sized plastic carrying case for medication and Adapter).

The Medihaler Principle

is also available in Medihaler-Nitro™ (octyl nitrite) for the rapid relief of angina pectoris ...and Medihaler-Phen™ (phenylephrine-hydrocortisone-neomycin) for lasting, effective relief of nasal congestion.

Riker LOS ANGELES

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 12 JUNE 1957 NUMBER 6

TABLE OF CONTENTS

SCIENTIFIC

Symposium on Disease and Aging, *Claire F. Ryder, M.D., Marian W. Ropes, M.D., Langdon Parsons, M.D., Priscilla White, M.D., and Robert T. Monroe, M.D.* 157
Sigmund Freud: To the One Hundredth Anniversary of His Birth, *Heinrich Meng, M.D.* Translated by *Ada Dunner, M.D.* 171
Women Doctors in Japan: Past and Present, *Kazue Ohara, M.D.* 175
Medical Highlights 181
World Health Organization 183
Books Received 196
Book Notices 197

ASSOCIATION

Retiring President's Message, *Camille Mermod, M.D.* 184
President's Message, *Elizabeth S. Kahler, M.D.* 185
Association News:
Medical Education 186
Legislation 187
Blackwell Awards of the New York Infirmary 188
News of Women in Medicine 190
Opportunities for Women in Medicine 192
International Hospitality 194
These Were the First, ELIZABETH BASS Collection 194
A Thanks Offering. A book review by *Margaret S. Tenbrinck, M.D.*, of "Women Doctors of the World," *Esther Pohl Lovejoy, M.D.* 195

MISCELLANEOUS

Editorial Board ..... Adv. p. 4
Board of Directors ..... Adv. p. 6
Branch Officers ..... Adv. p. 12
Junior Branch Officers ..... Adv. p. 26
Editorial Forecast ..... Adv. p. 33
Officers of the MWIA ..... Adv. p. 34
Index to Advertisers ..... Adv. p. 40
Index to Products Advertised ..... Adv. p. 40

Neither the Editor nor the Publisher of the Journal of the American Medical Women's Association is responsible for any statements made or opinions expressed by any of its contributors.

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is published monthly by the American Medical Women's Association, Inc., at 136 4th Ave., North, Nashville 3, Tenn. Entered as second class matter at the Post Office at Nashville, Tennessee, under the Act of August 24, 1912. Acceptance for mailing at special rates of postage provided for in Section 1102, Act of October 3, 1917, and authorized July 13, 1918. Copyright 1957 by the American Medical Women's Association, Inc. Subscription, $5.00 per year; $1.00 single copy.
EDITORIAL AND ADVERTISING OFFICE, Journal of the American Medical Women's Association, 1790 Broadway, New York 19, N. Y. Telephone Judson 6-8683. Advertising Manager, Joseph Bourgholtzer, Box 281, Suffern, N.Y. Telephone Lafayette 9-3044 (Mahwah, New Jersey).

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION

1790 Broadway, New York 19, N.Y.

Editorial Board

JANET K. AITKEN, C.B.E., M.D., F.R.C.P.....*London, England*
INES L. C. DE ALLENDE, M.D.....*Cordoba, Argentina*
MARY M. CRAWFORD, M.D.....*New York, N.Y*
BEULAH CUSHMAN, M.D.....*Chicago, Ill.*
MARIA PAUMGARTTEN DEANE, M.D.....*Belem, Para, Brazil*
GLADYS H. DICK, M.D.....*Chicago, Ill.*
EDNA M. GUEST, O.B.E., M.D.....*Toronto, Canada*
MARGARET H. JONES, M.D.....*Los Angeles, Calif*
JOSEPHINE H. KENYON, M.D.....*Boulder, Colo.*
ELIZABETH KITTREDGE, M.D.....*Washington, D.C.*
IRENE A. KOENEKE, M.D.....*Halstead, Kan.*
ESTHER P. LOVEJOY, M.D.....*New York, N.Y.*
CATHARINE MACFARLANE, M.D.....*Philadelphia, Pa.*
MINNIE LEE MAFFETT, M.D.....*Dallas, Texas*
DAME A. LOUISE MCILROY, O.B.E., M.D.....*London, England*
HARRIETT C. MCINTOSH, M.D.....*New York, N.Y.*
LOUISE PEARCE, M.D.....*Belle Mead, N.J.*
GILDA PERAZA, M.D.....*Havana, Cuba*
ELLEN C. POTTER, M.D.....*Trenton, N.J.*
BARBARA B. STIMSON, M.D.....*Poughkeepsie, N.Y.*
EDNA H. TOMPKINS, M.D.....*Boston, Mass.*
RUTH WELLS, M.D.....*Pasadena, Calif.*
PRISCILLA WHITE, M.D.....*Boston, Mass.*

Specialists

Anesthesiology.....RITA JACOBS, M.D., *New York, N.Y.*
Cardiology.....TERESA MCGOVERN, M.D., *New York, N.Y.*
Endocrinology.....RITA FINKLER, M.D., *Newark, N.J.*
Gastroenterology.....MARIE ORTMAYER, M.D., *Littleton, Colo.*
Gynecology.....ELOISE PARSONS, M.D., *Chicago, Ill.*
Neurology.....KATE CONSTABLE, M.D., *New York, N.Y.*
Nutrition.....GRACE GOLDSMITH, M.D., *New Orleans, La.*
Obstetrics.....ANNE S. MASTER, M.D., *Cleveland, Ohio*
Orthopedic Surgery.....RUTH JACKSON, M.D., *Dallas, Texas*
Pathology.....EDITH L. POTTER, M.D., *Chicago, Ill.*
Pediatrics.....MARY B. OLNEY, M.D., *San Francisco, Calif.*
Physical Medicine and Rehabilitation.....NILA K. COVALT, M.D., *Lake Park, Fla.*
Plastic Surgery.....ALMA DEA MORANI, M.D., *Philadelphia, Pa.*
Psychiatry.....ANNA COYNE TODD, M.D., *Washington, D.C.*
Public Health....HELEN M. WALLACE, M.D., *Minneapolis, Minn.*
Radiology....ELIZABETH SCHULZE HEALD, M.D., *Berkeley, Calif.*
Surgery.....ANNELLA BROWN, M.D., *Boston, Mass.*
Urology.....OCCO E. GOODWIN, M.D., *San Francisco, Calif.*

EDITOR
FRIEDA BAUMANN, M.D.

ASSISTANT EDITORS
MARCELLE BERNARD, M.D.
MARGARET S. TENBRINCK, M.D.

MANAGING EDITOR
NORMA E. GOODMAN

BUSINESS MANAGER
GERTRUDE F. CONROY

DEPARTMENTAL EDITORS

Recent Advances in Medicine
FRANCES L. BOGATKO, M.D.
New York, N. Y.

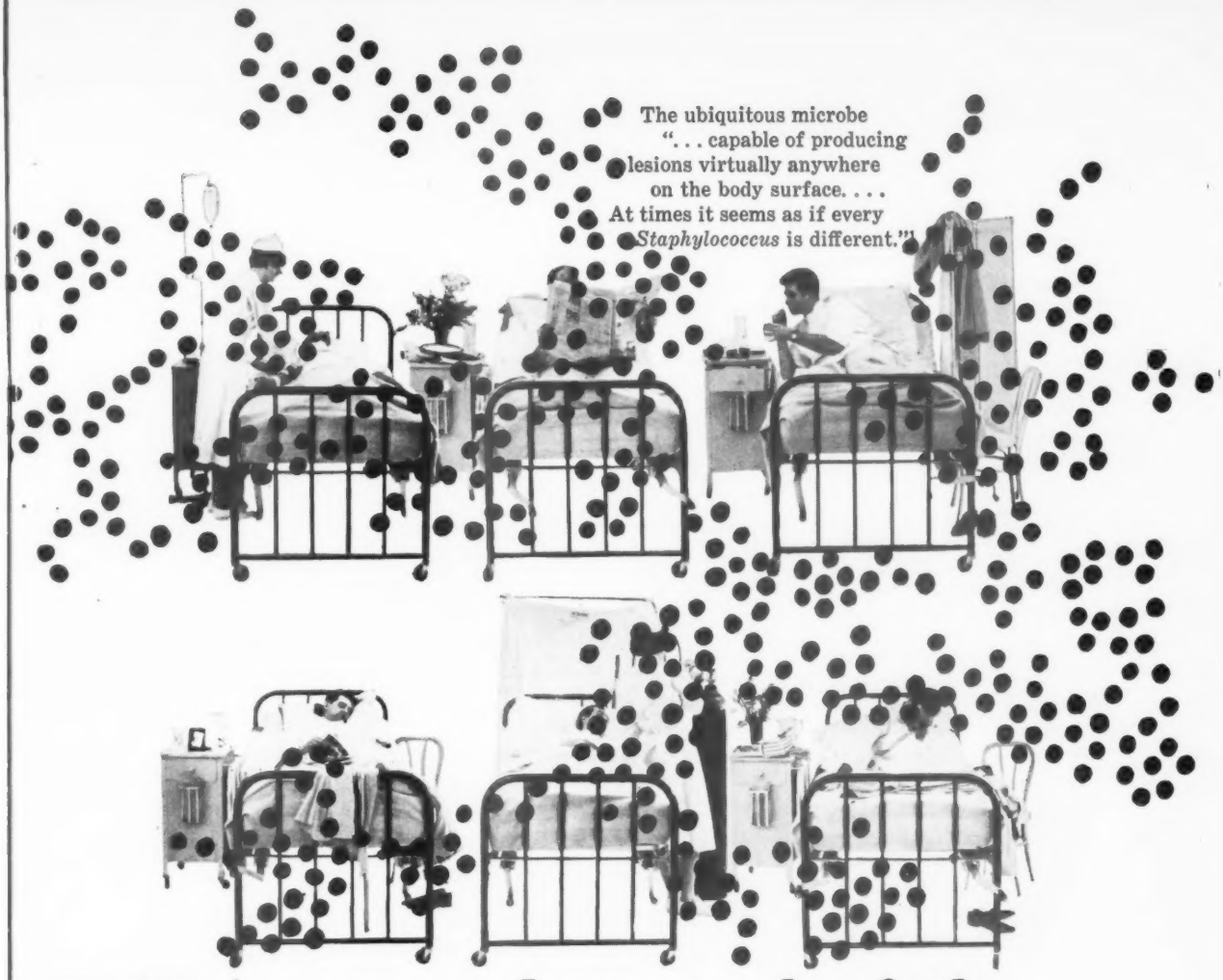
Modern Concepts of Physiology
ESTHER M. GREISHEIMER, M.D.
Philadelphia, Pa.

Book Reviews
E. COOPER BELL, M.D.
MARGARET HAY EDWARDS, M.D.
Philadelphia, Pa.
HELEN STEVENS HASKELL, M.D.
New York, N.Y.

Reports of Proceedings
MARGARET S. TENBRINCK, M.D.
New York, N.Y.

Medical School Student News
EVA F. DODGE, M.D.
Little Rock, Ark.

Chairman of Publications Committee, ELIZABETH S. WAUGH, M.D., Philadelphia, Pa.


The ubiquitous microbe
". . . capable of producing
lesions virtually anywhere
on the body surface. . . .
At times it seems as if every
Staphylococcus is different."[1]

now improved control of the ubiquitous Staph. with new

MATROMYCIN®

BRAND OF OLEANDOMYCIN

for the common bacterial infections that you treat with antibiotics other than broad spectrum . . . clinical success even in cases of antibiotic-resistant staphylococci

- no predictable cross resistance with penicillin, erythromycin, streptomycin, tetracycline, oxytetracycline and chlortetracycline
- resistance to Matromycin itself does not readily occur and emerges slowly and in adaptive fashion, as shown by experiments with various strains of *M. pyogenes* (clinical isolates)[2]
- outstandingly safe and well tolerated

Available in 250 mg. capsules, bottles of 16

references: 1. McDermott, W.: Ann. New York Acad. Sc. *65*:59 (Aug. 31) 1956. 2. Noyes, H. E.; Nagle, S. C., Jr.; Sanford, J. P., and Robbins, M. L.: Antibiotics & Chemother. *6*:450 (July) 1956.

Pfizer

PFIZER LABORATORIES, Brooklyn 6, N.Y.
Division, Chas. Pfizer & Co., Inc.
World leader in antibiotic development and production

American Medical Women's Association, Inc.

BOARD OF DIRECTORS
1956-1957

OFFICERS

President: CAMILLE MERMOD, M.D., 294 S. Centre St., Orange, N.J.
President-Elect: ELIZABETH S. KAHLER, M.D., 3828 Fulton St., N.W., Washington, D.C.
Retiring President: ESTHER C. MARTING, M.D., 2314 Auburn Ave., Cincinnati, Ohio.
First Vice-President: EDITH PETRIE BROWN, M.D., 441 Turney Rd., Bedford, Ohio.
Second Vice-President: GERTRUDE FLINT JONES, M.D., 490 Post St., San Francisco, Calif.
Recording Secretary: ANAH WINEBERG, M.D., 3120 Webster St., Oakland, Calif.
Corresponding Secretary: FRANCES ARTHUR, M.D., 138 Westfield Ave., Elizabeth, N.J.
Treasurer: ELIZABETH R. FISCHER, M.D., 10401 S. Bell Ave., Chicago 43, Ill.
Assistant Treasurer: MARY MARGARET FRAZER, M.D., 76 W. Adams St., Detroit, Mich.

PAST PRESIDENTS

ELIZABETH S. WAUGH, M.D., 348 Green Lane, Philadelphia 28, Pa.
AMEY CHAPPELL, M.D., 3391 Peachtree St., N.E., Atlanta, Ga.
EVANGELINE STENHOUSE, M.D., 55 E. Washington St., Chicago 2, Ill.
JUDITH AHLEM, M.D., 954 South L St., Livermore, Calif.

REGIONAL DIRECTORS

New England (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut):
CLAIRE F. RYDER, M.D., 11 Tetlow St., Boston 15, Mass. (1955-1958)

North Atlantic (New York, Pennsylvania, New Jersey, Delaware):
ALMA DEA MORANI, M.D., 3665 Midvale Ave., Philadelphia, Pa. (1955-1957)

Middle Atlantic (Maryland, District of Columbia, Virginia, West Virginia, Foreign):
ELEANOR SCOTT, M.D., 1014 St. Paul St., Baltimore, Md. (1954-1957)

South Atlantic (North Carolina, South Carolina, Georgia, Florida, Puerto Rico):
R. CHARMAN CARROLL, M.D., 406 Montford Ave., Asheville, N.C. (1954-1957)

Northeast Central (Ohio, Indiana, Illinois, Michigan, Wisconsin):
MARGARET STANTON, M.D., 5625 W. Division, Chicago, Ill. (1955-1958).

Southeast Central (Kentucky, Tennessee, Alabama, Mississippi, Louisiana):
MARGARET L. KERR, M.D., Charity Hospital, New Orleans, La. (1954-1957)

Northwest Central (Minnesota, Iowa, North Dakota, South Dakota, Nebraska):
GRACE SAWYER, M.D., Woodward, Iowa. (1955-1957)

Southwest Central (Missouri, Arkansas, Kansas, Oklahoma, Texas):
ANITA JOHNSON MCNEELY, M.D., 1719 Pacific Ave., Dallas, Texas. (1955-1957)

Northwest (Montana, Wyoming, Idaho, Washington, Oregon, Alaska):
IRENE GRIEVE, M.D., 525 Fernwell Bldg., Spokane, Wash. (1956-1959)

Southwest (Colorado, New Mexico, Utah, Arizona, California, Nevada, Hawaii):
PEARL KONTTAS, M.D., 114 Sotoyome Ave., Post Office Box 1374, Santa Rosa, Calif. (1956-1959)

* * * *

Director of Junior Membership:
ESTHER C. MARTING, M.D., 2314 Auburn Ave., Cincinnati, Ohio.

* * * *

Chairmen of Standing Committees (see page 8)

* * * *

Editor of the Journal of the American Medical Women's Association:
FRIEDA BAUMANN, M.D., 1790 Broadway, New York 19, N.Y.

HEADQUARTERS: 1790 Broadway, New York 19, N.Y., Circle 5-8000, ext. 8
Executive Secretary: LILLIAN T. MAJALLY

in allergic eczemas

Meti-Derm CREAM 0.5%

water washable—stainless

(METICORTELONE, free alcohol)

Meti-Derm OINTMENT 0.5%

with Neomycin

5 mg. METICORTELONE and 5 mg. Neomycin Sulfate for comprehensive topical therapy

each in 10 Gm. tubes

Schering

MD-J-117

METI-DERM,® brand of prednisolone topical.
METICORTELONE,® brand of prednisolone.
®T.M.

BOARD OF DIRECTORS—(Continued)
CHAIRMEN OF STANDING COMMITTEES, 1956-1957

Auditing
DOROTHY M. ROGERS, M.D.
50 Cooper St., Woodbury, N. J.

Credentials
ROSA LEE NEMIR, M.D.
303 E. 20th St., University Hospital
New York 3, N. Y.

Constitution and By-Laws
EVA BRODKIN, M.D.
365 Osborn Terrace, Newark 8, N. J.

Elections
MATHILDA VASCHAK, M.D.
104 Myrtle Ave., North Plainfield, N. J.

Finance
ANTOINETTE LEMARQUIS, M.D.
704 Medical-Dental Bldg., San Diego, Calif.

History of Medicine
MARGARET NOYES KLEINERT, M.D.
23 Bay State Rd., Boston 15, Mass.

International
ADA CHREE REID, M.D.
118 Riverside Drive, New York 24, N. Y.

Legislative
ALMA JANE SPEER, M.D.
3232 Garfield St., N.W., Washington, D. C.

Library
ROSE V. MENENDIAN, M.D.
6900 N. Western Ave., Chicago, Ill.

Medical Education
ELIZABETH VEACH, M.D.
Overlook Sanatarium, New Wilmington, Pa.

Medical Service—American Women's Hospitals
ESTHER P. LOVEJOY, M.D.
50 W. 50th St., New York 20, N. Y.

Nominating
ESTHER C. MARTING, M.D.
2314 Auburn Ave., Cincinnati, Ohio

Opportunities
ELOISE PARSONS-BAKER, M.D.
30 N. Michigan Ave., Chicago 2, Ill.

Organization and Membership
GERTRUDE FLINT JONES, M.D.
490 Post St., San Francisco 2, Calif.

Publications
ELIZABETH S. WAUGH, M.D.
348 Green Lane, Philadelphia 28. Pa.

Public Health
ELEANOR BYERS PETRIE, M.D.
304 Wilton Drive, Decatur, Ga.

Public Relations and Publicity
MARY TYLER, M.D.
1435 North Ave., Waukegan, Ill.

Scholarships
ANN GRAY TAYLOR, M.D.
6364 Germantown Ave., Philadelphia 44, Pa.

Woman's Medical College of Pennsylvania
CATHARINE MACFARLANE, M.D.
701 Medical Arts Bldg., Philadelphia, Pa.

Reference Committee A
JOSEPHINE RENSHAW, M.D.
1150 Connecticut Ave., Washington 6, D.C.

SPECIAL COMMITTEES

Midyear Meeting
MARGARET NOYES KLEINERT, M.D.
23 Bay State Rd., Boston 15, Mass.

Survey of Women Physicians
FRANCES HANNETT, M.D.
5490 South Shore Drive, Chicago 15, Ill.

Woolley Memorial Committee
THERESA SCANLAN, M.D.
133 E. 58th St., New York, N.Y.

APPOINTED REPRESENTATIVE

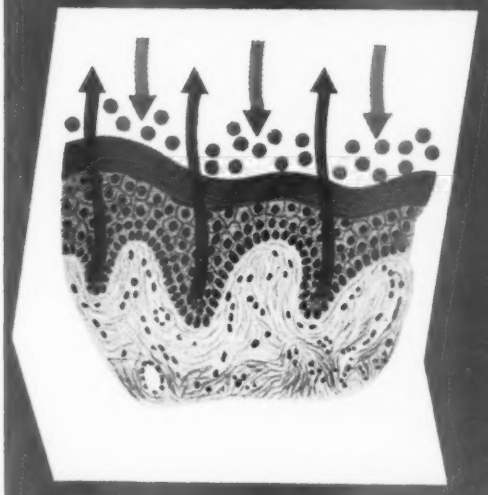
HELENA RATTERMAN, M.D.
126 William Taft Rd., Cincinnati 19, Ohio

STATE DIRECTORS

California: JANE SCHAEFER, M.D., 490 Post St., San Francisco.
Colorado: MILDRED DOSTER, M.D., 1015 Colorado Blvd., Denver 6.
Connecticut: SOPHIE C. TRENT, M.D., 236 W. Main St., Meriden.
Eastern Massachusetts: CLAIRE F. RYDER, M.D., 11 Tetlow St., Boston 15.
Idaho: JANE DOERING GUMPRECHT, M.D., 302 N. Fifth St., Coeur d' Alene.
Indiana: CLEMENTINE FRANKOWSKI, M.D., 1907 New York Ave., Whiting.
Illinois: ROSE V. MENENDIAN, M.D., 2400 W. Morse Ave., Chicago.
Iowa: EVLYN M. ANDERSON, M.D., 816 Equitable Bldg., Des Moines.
New Hampshire and Vermont: AUGUSTA FOSTER LAW, M.D., 16 South St., Milford.
New Mexico (Co-Directors): EVELYN F. FRISBIE, M.D., and LUCY MCMURRAY, M.D., 200 N. Walter St., Albuquerque.
Ohio (Co-Chairmen): MARJORIE GRAD, M.D., 1506 Chase Ave., Cincinnati.
JEANNE E. NITCHALS, M.D., 2205 Beechmont Ave., Cincinnati.
Oregon: MARTHA VAN DER VLUGHT, M.D., John Day.
Pennsylvania: REBECCA M. RHOADS, M.D., 416 Chichester Lane, Wynnewood.
Utah: CAMILLA ANDERSON, M.D., 239 Virginia St., Salt Lake City.
Washington: BERNICE SACHS, M.D., 200 15th Ave., Seattle 2.
Western Massachusetts: MARY C. SHANNON, M.D., 28 Pleasant St., Worcester.
Wisconsin: ELSINE MOORE THOMAS, M.D., 200 E. Wells St., Milwaukee.

discontinuous film
protects without occlusion

PROOF



Discontinuous film formed by Johnson's Baby Lotion permits acceptance of water from underlying tissues and escape of water to the environment as well as normal respiratory function.

- helps combat miliaria, other irritations
- enhances antibacterial action

Contains hexachlorophene, 0.5 per cent

bettering baby care through specialized research

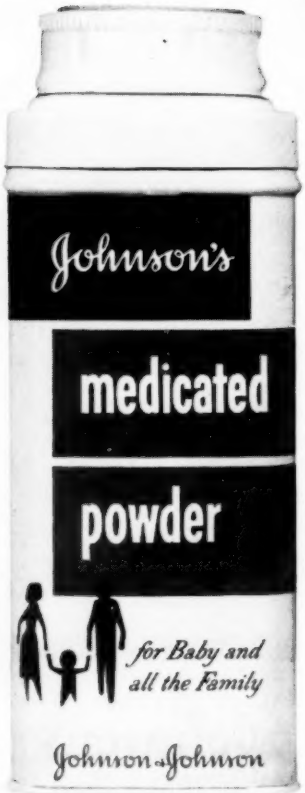
BABY PRODUCTS DIVISION

Johnson & Johnson

NEW! for patients of all ages

prevents and relieves skin discomforts

aids healing



*CONTAINS HEXACHLOROPHENE 0.25 PER CENT AND PARA-CHLORO-META-XYLENOL 0.25 PER CENT.

Superior Antibacterial Action*

Zones of Growth Inhibition – Agar Plate Tests
(Zone sizes in millimeters)

TEST ORGANISM	JOHNSON'S MEDICATED POWDER	MEDICATED POWDER A	MEDICATED POWDER B
Proteus vulgaris	5.0	0.0	0.0
Micrococcus pyogenes var. albus	6.5	0.0	0.0
Micrococcus pyogenes var. albus hemolyticus	5.5	0.0	0.0
Micrococcus pyogenes var. aureus hemolyticus	5.5	0.0	0.0
Micrococcus pyogenes var. aureus (Wellcome strain CN491)	6.5	0.0	0.0
Alcaligenes faecalis	10.0	0.0	(3.0)†

†PARTIAL GROWTH INHIBITION

antibacterial: twofold antiseptic action curbs primary infections, helps prevent secondary infections.

anti-urease: specific inhibition of the enzyme urease plus action against urease-producing bacteria checks formation of ammonia...prevents diaper rash and ammoniacal dermatitis.

superior absorption: two highly effective moisture absorbents help keep skin cool and dry...combat maceration, chafing and irritation.

JOHNSON'S MEDICATED POWDER provides unexcelled dry lubrication as well as effective deodorizing action. It is ideal for sensitive skin—completely safe for babies and children.

03087

Johnson & Johnson
New Brunswick, New Jersey

How to pep up a poor appetite

REDISOL

CYANOCOBALAMIN (CRYSTALLINE VITAMIN B_{12})

When REDISOL—pure vitamin B_{12}—is used as a dietary supplement, weight gain and increase in appetite often follow. The cherry-flavored Elixir and soluble Tablets dissolve readily in liquids.

MSD

MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

1790 Broadway **New York 19, N.Y.**

APPLICATION FOR ASSOCIATE MEMBERSHIP

Name.....Date.....

Address.....Present

Address.....Permanent

Please print or type name and address. Check address to which JOURNAL is to be mailed.

Medical School.....Year of Graduation.....

Place of Internship.....

Date of Birth.....Place of Birth.....

Associate members do not pay dues but have all the privileges of membership except voting, holding office, and membership in the Medical Women's International Association. Associate membership is open to: medical women in the first year of practice, women interns, residents in training, and fellows. Membership includes the JOURNAL each month without charge.

.....Signature

American Medical Women's Association, Inc.

BRANCH OFFICERS, 1956-1957

ONE, WASHINGTON, D.C.

President: Claudine Moss Gay, M.D., 403 E. Capitol, Washington 2, D.C.

Secretary: Vita Jaffee, M.D., 6301 W. Halbert Rd., Bethesda, Md.

Membership Chairman: Cecile L. Fusfeld, M.D., 2026 R. Street, N.W., Washington, D.C.

Meetings held first Tuesday, October to May.

TWO, CHICAGO, ILLINOIS

President: Rose V. Menendian, M.D., 2400 Morse Ave., Chicago 45.

Secretary: Julia Apter, M.D., 7135 S. Jeffery, Chicago 49.

Membership Chairman: Charlotte Kerr, M.D., 728 S. Ashland Ave., Chicago 7.

Meetings held monthly.

THREE, MARYLAND

President: Grace Hiller, M.D., Goucher College, Towson 4.

Secretary: Mary Matthews, M.D., 8106 Harford Rd., Baltimore 14.

Membership Chairman: Pearl L. Scholz, M.D., 11 Blythewood Rd., Baltimore 10.

Meetings held first Thursday of month.

FOUR, NEW JERSEY

President: Ruth Kidd, M.D., 1199 Morris Ave., Union.

Secretary: Gertrude Ash, M.D., 866 South 13th St., Newark.

Membership Chairman: Ella Coughlan, M.D., 10 Oakwood, Orange.

FIVE, PORTLAND, OREGON

President: Miriam Luten, M.D., 308 Taylor St. Bldg., (919 Taylor St.) Portland 5.

Secretary: Dorothy Vinton, M.D., 2455 N.W. Marshall, Suite 5, Portland 10.

Dinner meetings held every two months, with a symposium on scientific topics of general interest.

SIX, OMAHA, NEBRASKA

President: Aileen Mathiasen-Sciortino, M.D., 6 Hall St., Council Bluffs, Iowa.

Secretary: Louise M. Camel Farrage, M.D., 478 Elmwood, Council Bluffs, Iowa.

EIGHT, NEW ORLEANS, LOUISIANA

President: Georgiana J. von Langermann, M.D., 1430 Tulane Ave., New Orleans.

TEN, WISCONSIN

President: Elaine Pedersen, M. D., 6040 W. Lisbon Ave., Milwaukee.

Secretary-Treasurer: Mary Hall, M.D., 4042 N. Wilson Drive, Milwaukee.

ELEVEN, SOUTHWESTERN OHIO

President: Rae Hartman, M.D., 2002 Madison Rd., Cincinnati.

Secretary: Emily Wright, M.D., 421 Burns Ave., Cincinnati 15.

Meetings held second Tuesday, September, November, January, March, May.

TWELVE, COLUMBUS, OHIO

President: Dorothy F. Falkenstein, M.D., 188 E. State St., Columbus.

THIRTEEN, SAN DIEGO, CALIFORNIA

President: Margaret Siems, M.D., 4747 Mission Blvd., San Diego.

Secretary: Eunice Simmons, M.D., 430 Upas St., San Diego.

Meetings held every other month on fourth Thursday.

FOURTEEN, NEW YORK, NEW YORK

President: Adelaide Romaine, M.D., 35 W. 9th St., New York 11.

Secretary: Margaret S. Tenbrinck, M.D., 235 E. 22nd St., New York 10.

Membership Chairman: Estelle DeVito, M.D., 301 E. 21st St., New York 10.

FIFTEEN, CLEVELAND, OHIO

President: June Dvorak, M.D., 2235 Overlook Rd., Cleveland Heights 60.

Secretary: Jane McCollough, M.D., 2576 Traymore, University Heights 18.

SIXTEEN, PITTSBURGH, PENNSYLVANIA

President: Virginia E. Washburn, M.D., 4403 Center Ave., Pittsburgh 13.

Secretary: Marita Kenna, M.D., 4740 Liberty Ave., Pittsburgh 24.

EIGHTEEN, NEW YORK STATE

President: Anna P. Walsh, M.D., 391 Jersey St., Buffalo 4.

Secretary: Harriet Hosmer, M.D., 333 Linwood Ave., Buffalo 9.

Membership Chairman: Marguerite P. McCarthy-Brough, M.D., 1811 W. Genessee St., Syracuse.

NINETEEN, IOWA

President: Ada Dunner, M.D., Bankers Trust Building, Des Moines.

Secretary: Mary Croker, M.D., Manchester.

Meetings held each April, in conjunction with state medical meeting.

(Continued on page 18)

Prenatal Dri-kaps*

VITAMINS-MINERALS LEDERLE

inclusive dosage—exclusive capsule

You offer mother and child extra benefits when you specify PRENATAL DRI-KAPS—comprehensive, balanced multivitamin-multimineral supplementation (including 3 antianemia factors); exclusive DRI-KAPS formulation assuring more rapid and complete absorption. The dry-filled, sealed capsules (a Lederle exclusive) provide convenient, easy-to-swallow dosage, no aftertaste or oily repeat.

Each capsule contains:

Vitamin A	2000 U.S.P. Units
Vitamin D	400 U.S.P. Units
Thiamine Mononitrate (B_1)	2 mg.
Riboflavin (B_2)	2 mg.
Niacinamide	7 mg.
Vitamin B_{12}	1 mcgm.
Vitamin K (Menadione)	0.5 mg.
Ascorbic Acid (C)	35 mg.
Folic Acid	1 mg.
Calcium (in $CaHPO_4$)	250 mg.
Phosphorus (in $CaHPO_4$)	190 mg.
Dicalcium Phosphate Anhydrous ($CaHPO_4$)	869 mg.
Iron (in $FeSO_4$)	6 mg.
Ferrous Sulfate Exsiccated	20 mg.
Manganese (in $MnSO_4$)	0.12 mg.

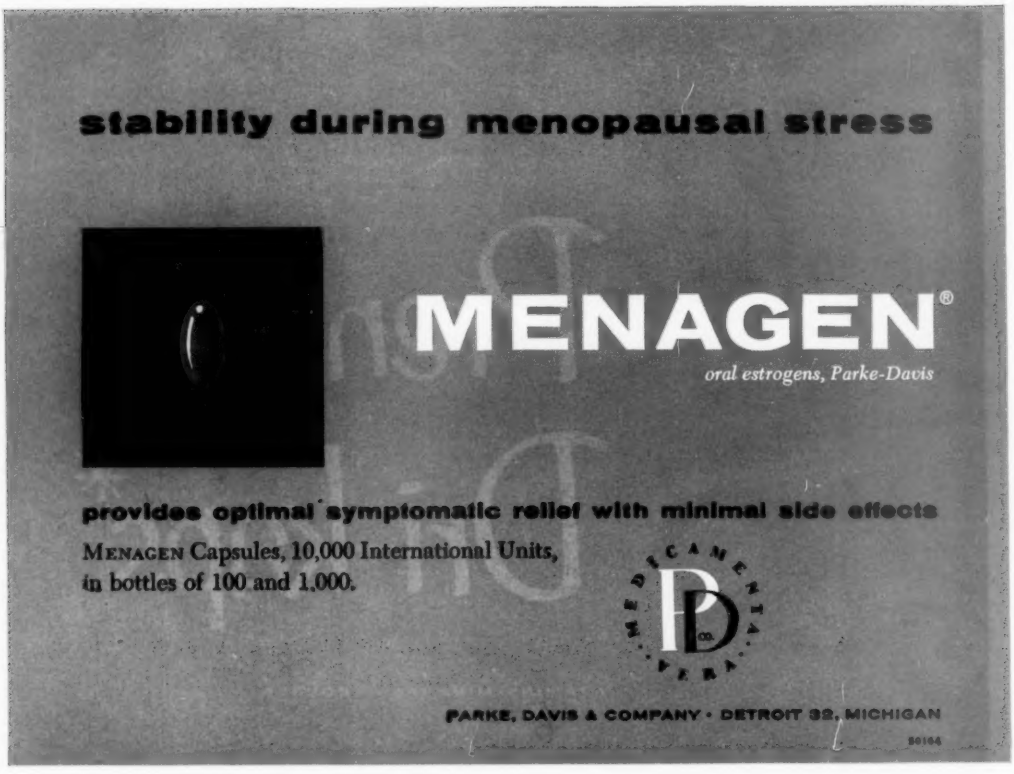
Dosage: 1 to 3 capsules, throughout pregnancy and lactation

ONE OF A COMPLETE LINE OF VITAMIN PRODUCTS
Lederle
FORMULATED UNDER RIGID QUALITY CONTROL FOR YOUR PRESCRIPTION NEEDS

*Trademark

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

Lederle


stability during menopausal stress
MENAGEN®
oral estrogens, Parke-Davis
provides optimal symptomatic relief with minimal side effects
MENAGEN Capsules, 10,000 International Units,
in bottles of 100 and 1,000.
PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

1790 Broadway New York 19, N.Y.

APPLICATION FOR JUNIOR MEMBERSHIP

Name.....
(Please Print or Type)

Date.....

Address (Present).....

Address (Permanent).....

(Please check address to which the JOURNAL and AMWA correspondence are to be mailed.)

Medical School.....Year of graduation.....

Place of expected internship.....

Date and place of birth.....

Junior membership does not require payment of dues.

Signature .....

"So then I *told* the doctor...
"*Why* do you have such an *unwholesome* attitude toward watercress and sal*tines*? You simply cannot *expect* the girls in the Henry Hudson Fowl Protection League to eat big, *heavy*, fattening *meals* . . ."

When you finally bring her around, remember that what she'll probably need first . . . and *most* . . . is the essential B-complex. And that's a good time for

A GOOD
B-COMPLEX

sur-Bex® with C

(Abbott's B-Complex Tablets with C)

706179

Just one Sur-Bex tablet a day supplies:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	1 mg.
Vitamin B_{12} (as cobalamin concentrate)	2 mcg.
Calcium Pantothenate	10 mg.
Ascorbic Acid	150 mg.
Desiccated Liver, N. F.	300 mg.
Brewer's Yeast, Dried	150 mg.

As a dietary supplement: 1 or 2 tablets daily
In convalescence: 2 or more daily

Abbott

THE PICTURE OF COMFORT ALL THROUGH THE PREGNANCY
if she's blue at breakfast...
BONADOXIN®
(brand of Meclizine HCl and Pyridoxine HCl)
stops morning sickness
Controlled studies indicate that BONADOXIN relieves symptoms quickly—in 9 of every 10 gravida. Tolerance is excellent.
Prescribe: One tablet at bedtime. Severe cases, one tablet at bedtime, one on arising. In tiny pink-and-blue tablets, bottles of 25 and 100. ℞ only.
if she needs a nutritional buildup—and freedom from leg cramps†
prescribe STORCAVITE®
Phosphate-free calcium, iron, 10 essential vitamins, 8 important minerals.
Usually 3 tablets daily, with meals. In bottles of 100.
†when due to a high phosphorous intake.
Rx
CHICAGO 11, ILLINOIS
PEACE of mind ATARAX®

Name	Address	Tel No.	Occupation	Age
Edwards, Iva (Mrs.)	672 5th Ave.	AB 4-4134	Laundry	43

JCM 484331

Ref. by Mrs. Wilson

Date:

2/4/57 Heavy set, works in hot environment, nylon bra. Eruption under breasts - folliculitis, 1 day - erythema, 3 days - eczematized eruption past week - pruritus, weeping, fissure. Has used several 'salves' and drying lotions, caused burning and spread.

FH-PH: No diabetes, systemic disease

Dx: Intertrigo, inframammary

Worth trying—

PRODUCT INFORMATION

TASHAN CREAM 'Roche'

SOOTHING, HEALING MULTIVITAMIN SKIN CREAM

DESCRIPTION: Tashan Cream provides four vitamins to help maintain skin health and promote healing.

Each gram (approx. 1/30 ounce) contains:

Vitamin A . . . . . 10,000 U.S.P. units
Vitamin D_2 . . . . . 1,000 U.S.P. units
d-Panthenol . . . . . 50 mg (5%)
Vitamin E (*dl*-alpha-tocopheryl acetate) . . . 5 mg

in a cosmetically pleasing, vanishing cream type base.

PROPERTIES: Vitamins A and D help maintain skin health; inhibit keratin formation; promote smoother, softer skin. Vitamin E is antipruritic; exerts a trophic effect through stimulation of skin metabolism. Panthenol is essential for integrity of tissue in general, promotes epithelization.

INDICATIONS: To relieve symptoms and promote healing in skin disorders characterized by itching, dryness, fissures, superficial ulceration, delayed cicatrization, etc., including:

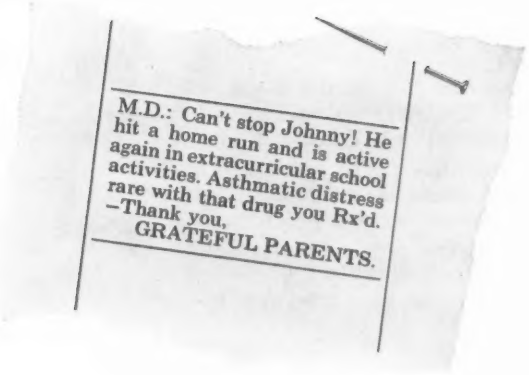
Eczema	Nipple conditioning
Diaper rash	Minor burns
Prickly heat	Contact dermatitis
Intertrigo, chapping	Pruritus ani and vulvae
Sunburn, windburn	Diabetic skin disorders
Decubitus ulcers	Excoriation

DOSAGE: Apply a thin layer of Tashan Cream and rub in gently, three or more times daily.

PACKAGES: 1 ounce tubes.

Tashan®

Hoffmann-La Roche Inc • Nutley • New Jersey


M.D.: Can't stop Johnny! He hit a home run and is active again in extracurricular school activities. Asthmatic distress rare with that drug you Rx'd.
–Thank you,
GRATEFUL PARENTS.

Sterane®

brand of prednisolone

Most active corticoid; minimal disturbance of electrolyte balance. White, scored 5 mg. tablets (bottles of 20 and 100) and pink, scored 1 mg. tablets (bottles of 100).

Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

American Medical Women's Association, Inc.

BRANCH OFFICERS, 1956-1957—(Continued)

TWENTY (BLACKWELL), DETROIT MICHIGAN

President: Katheryn L. O'Connor, M.D., 14301 Grand River Ave., Detroit 27.

Secretary: Dorothy D'Sena, M.D., 22470 Nona, West Dearborn.

Meetings held five times a year.

TWENTY-THREE, LOS ANGELES, CALIFORNIA

President: Juyne M. Tayson, M.D., 5414 N. Figueroa St., Los Angeles 12.

Secretary: Ethel M. Hamilton, M.D., 5740 York Blvd., Los Angeles 42.

Membership Chairman: Elizabeth Mason-Hohl, M.D., 1234 Vermont Ave., Hollywood.

TWENTY-FOUR, KANSAS

President: Mary T. Glassen, M.D., Phillipsburg.

Secretary: Ruth P. Spiegel, M.D., Formosa.

Next meeting will be held on call.

TWENTY-FIVE, PHILADELPHIA, PENNSYLVANIA

President: Helen E. di Silvestro, M.D., 6362 Drexel Rd., Philadelphia 31.

Secretary: Joan H. Buchanan, M.D., Watersmeet, Glen Mills.

Membership Chairman: Lucy A. La Salvia, M.D., 3001 W. Queen Lane, Philadelphia 29.

Meetings held three times a year.

TWENTY-SIX, MINNESOTA

President: Della G. Drips, M.D., Oronoco.

Secretary: Nellie N. Barsness, M.D., 540 Lowry Medical Arts Bldg., St. Paul.

TWENTY-NINE, ATLANTA, GEORGIA

President: Vernelle Fox, M.D., 1293 W. Peachtree St., N.W., Atlanta.

Secretary: Eleanor Bundy, M.D., 706 Church St., Decatur.

Membership Chairman: Virginia Tuggle, M.D., 822 Columbia Drive, Atlanta.

Meetings held third Saturday, alternate months.

THIRTY, UPPER CALIFORNIA

President: Mary C. Thompson, M.D., 450 Sutter St., San Francisco 8.

Secretary: Joan Davidson, M.D., 2107 Van Ness Ave., San Francisco.

THIRTY-ONE, MISSISSIPPI

President: Eva L. Meloan, M.D., 964 N. State St., Jackson.

Secretary: Ruth R. Burroughs, M.D., 2912 N. State St., Jackson.

THIRTY-TWO, WESTERN NORTH CAROLINA

President: Ethel Brownsberger, M.D., 75 Hendersonville Rd., Biltmore.

Secretary: Louise Galloway, M.D., 25 Arthur Rd., W. Asheville.

THIRTY-THREE, FLORIDA

President: Mary C. Patras, M.D., 8340 N.E. Second Ave., Miami 38.

Secretary: Minerva Gordon, M.D., 541 Lincoln Rd., Miami Beach.

THIRTY-FOUR, ARKANSAS

President: Elizabeth D. Fletcher, M.D., 705 Donoghey Bldg., Little Rock.

Secretary: Martha M. Brown, M.D., State Hospital, Little Rock.

THIRTY-FIVE, PUERTO RICO

President: Alice Reinhardt, M.D., Santorio Insula, Rio Piedros.

Secretary: Maria Amelia Pares, M.D., Professional Building, Santurce.

THIRTY-SIX, ALAMEDA COUNTY, CALIFORNIA

President: Miriam Rutherford, M.D., 2929 Summit St., Oakland.

Secretary: Dorothy McDonald, M.D., 2490 Channing Way, Berkeley.

THIRTY-SEVEN, SEATTLE, WASHINGTON

President: Phyllis Leibly, M.D., 4530 51st St., N.E., Seattle.

Secretary: Lily E. Schoffman, M.D., 828 Fourth and Pike Bldg., Seattle.

THIRTY-EIGHT, LONG BEACH, CALIFORNIA

President: Sybil Haire, M.D., 5221 Arbor Rd., Long Beach 11.

Secretary: Georgia L. Johnson, M.D., 4029 Elm Ave., Long Beach 7.

THIRTY-NINE, BOSTON, MASSACHUSETTS

President: Margaret Noyes Kleinert, M.D., 23 Bay State Rd., Boston.

Secretary: Patricia Benedict, M.D., 24 Essex Rd., Chestnut Hill 67.

Membership Chairman: Mary C. Shannon, M.D., 334 Highland St., Worcester.

FORTY, DALLAS, TEXAS

President: Katharine Bennett, M.D., 915 St. Joseph, Dallas.

Secretary: Harriet Rogers, M.D., 4307 Camden, Dallas.

(Continued on page 21)

Please report all changes in Branch officers and chairmen as soon as possible to American Medical Women's Association, 1790 Broadway, New York 19, N.Y.

they know what they like

you know what they need for comprehensive vitamin protection

Deca-Mulcin®

delicious orange-flavored teaspoon dosage of 10 nutritionally significant vitamins

- assured stability, including B_{12}
- non-sticky, free flowing
- no refrigeration required
- pouring lip bottles of 4, 8 and 16 oz.

Deca-Vi-Caps®

small easy-to-swallow capsules of 10 nutritionally significant vitamins

- potency assured
- inviting red color
- store anywhere
- bottles of 30 and 100

and for the dropper-dosage age—Specify Deca-Vi-Sol®

These three Deca Family Products have the same basic formulation and the same standard of comprehensive protection. The basic family name Deca is easy to remember and simplifies specification during the vital first decade.

MEAD JOHNSON

SYMBOL OF SERVICE IN MEDICINE

25757

"Nausea and vomiting of pregnancy were treated by the following remedies: intravenous pyridoxine, oral pyridoxine, oral thiamine chloride, sedation and psychotherapy had failed. Each patient was given 100 mg. of Dramamine three times daily. This dose was reduced to 50 mg. three times daily. 72.1 per cent of the patients were completely relieved of their symptoms three hours after administration of Dramamine."

Rehfuss, M. E., and Price, A. H.: A Course in Practical Therapeutics, ed. 3, Baltimore, The Williams & Wilkins Company, 1956, p. 534.

Nausea and Vomiting of Pregnancy

Dramamine®

Brand of Dimenhydrinate

SEARLE

in menopausal turmoil

THEELIN R-P*

- **rapid relief** for immediate need
- **prolonged action** for continuing need
- **unvarying potency** for dependable management of menopausal stress

THEELIN R-P is supplied in 10 cc. Steri-Vials.® Each cc. contains 2 mg. of THEELIN (20,000 International Units) and 1 mg. of Potassium THEELIN Sulfate in physiologic sodium chloride solution.

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

American Medical Women's Association, Inc.

BRANCH OFFICERS, 1956-1957
(Continued)

FORTY-ONE, SOUTHEAST VIRGINIA

President: Hertha Riese, M.D., Route 2, Box 397, Glen Allen.

Secretary: Maysville Owens Page, M.D., 2904 Rugby Rd., Richmond.

FORTY-TWO, HOUSTON, TEXAS

President: Ethel E. Erickson, M.D., 2044 Dryden Rd., Houston.

Secretary: Marga H. Sinclair, M.D., 3707 Ingold, Houston.

FORTY-THREE, THE ALAMO, SAN ANTONIO, TEXAS

President: Mary Mitchell Henry, M.D., 601 Medical Arts Bldg., San Antonio.

Secretary: Ione Huntington, M.D., 647 New Moore Bldg., San Antonio.

Membership Chairman: Pearl Zink, M.D., 615 Medical Arts Bldg., San Antonio.

FORTY-FOUR, MARICOPA, PHOENIX, ARIZONA

President: Zdenka Hurianek, M.D., 4115 N. 10th, Phoenix.

Secretary: Helen Davis, M.D., 3337 E. Mitchell Drive, San Antonio.

FORTY-FIVE, TUCSON, ARIZONA

President: Virginia C. Van Meter, M.D., Old Pueblo Club, Tucson.

FORTY-SIX, UTAH

President: Camilla Anderson, M.D., 239 Virginia St., Salt Lake City.

FORTY-SEVEN, COLORADO

President: Mildred Doster, M.D., 1015 Colorado Blvd., Denver 6.

FORTY-EIGHT, NORTHWEST INDIANA

President: Eleanore A. Walters, M.D., 602 Broadway, Gary.

Secretary: Ellen K. Cohen, M.D., Hebron.

NYLMERATE

the proven..

NYLMERATE JELLY . . . for vaginal discharges . . . **WARRANTS** your considered judgment. Offers **PROVEN CONTROL**

- Effective Trichomonicidal and Monilicidal action
- Symbiotic organisms eradicated by its bactericidal potency
- Low surface tension allows for deep epithelial cell penetration
- Restores vaginal flora to normal healthy biology
- Simple to use . . . . morning and night applications, including treatment during menstrual period

For that first prescription: "Nylmerate Jelly with applicator"

Availability: 3 oz. and 5 oz. tubes with applicators — 3 oz. and 5 oz. refill tubes

NYLMERATE SOLUTION CONCENTRATE . . . (concomitant measure) . . . when vaginal douching is required.

Available: In pint and 8 oz. bottles with measuring caps

(Nylmerate: A brand of phenylmercuric acetate)

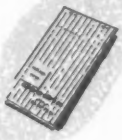
- Acidic (4.1 pH dilution)
- Therapeutic (trichomicidal and bactericidal)
- Reaches innermost recesses via low surface tension
- Ideal as a prophylaxis measure
- Available only on prescription (eliminates possibility of excessive or unwarranted vaginal douching)
- Economical
- Use . . twice daily (2 tablespoonsful to 2 qts. water) prior to insertion of medication

Holland-Rantos Co., Inc. Manufacturers of **KOROMEX** Products, New York 13, N. Y.

Three essential steps in establishing correct eating patterns:

1

SUPERVISION BY THE PHYSICIAN[1,2,3]



2

A BALANCED EATING PLAN[1,2,3]

In the development and maintenance of good eating habits, there are three essentials: support and supervision by the physician, a balanced eating plan, and selective medication.[1,2,3]

3

SELECTIVE MEDICATION[1,2,3]

OBEDRIN PROVIDES:

- Methamphetamine for its anorexigenic and mood-lifting effects.
- Pentobarbital as a balancing agent, to guard against excitation.
- Vitamins B_1 and B_2 plus niacin to supplement the diet.
- Ascorbic acid to aid in the mobilization of tissue fluids.

Since Obedrin contains no artificial bulk, the hazards of impaction are avoided. The 60-10-70 Basic Plan provides for a balanced food intake, with sufficient protein and roughage.

1. Eisfelder, H.W.: Am. Pract. & Dig. Treat. *5*:778 (Oct. 1954).
2. Freed, S.C.: G.P. *7*:63 (1953).
3. Sherman, R.J.: Medical Times, *82*:107 (Feb. 1954).

Obedrin®

and the 60-10-70 Basic Plan

FORMULA:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine mononitrate 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

Write for 60-10-70 Menu pads, weight charts and clinical supply of Obedrin.

THE S. E. MASSENGILL COMPANY

BRISTOL, TENNESSEE

NEW YORK • KANSAS CITY • SAN FRANCISCO

FOR THREE GENERATIONS, PHARMACIES HAVE SUPPLIED ANTACID, EFFERVESCENT

Sal Hepatica®

Since 1897, pharmacists have been dispensing SAL HEPATICA—the fast-acting yet gentle laxative.

Because sparkling SAL HEPATICA is both antacid and effervescent, it passes rapidly through the stomach. In the intestine it provides fluid bulk by its osmotic action. This bulk stimulates peristalsis. Prompt evacuation usually follows—within an hour, if taken before breakfast—before bedtime, if taken half an hour before the evening meal.

SAL HEPATICA is pleasant-tasting, acts without griping, therefore is liked by patients. Because it is antacid, it relieves the gastric hyperacidity frequently accompanying constipation.

BRISTOL-MYERS CO., 19 West 50 Street, New York 20, N. Y.

ORTHO'S

MOST SPERMICIDAL CONTRACEPTIVE

maximum concentration of a new,
most potent, well tolerated spermicide–
effective and acceptable

"In our opinion, the new contraceptive cream [DELFEN vaginal cream], when used alone, is highly spermicidal, and a satisfactory method of conception control. Its relative simplicity makes it very acceptable to the patient."

Ortho

JUNIOR BRANCH OFFICERS, 1956-1957

UNIVERSITY OF ALABAMA

President: Maude Dieseker, 800 S. 20th St., Birmingham.

Secretary: Betty Jean McBride, 800 S. 20th St., Birmingham.

Sponsor: Evelyn L. Stansell, M.D., 314 N. 15th St., Bessemer.

UNIVERSITY OF ARKANSAS

President: Betty Jane McClellan, 222 W. "G" St., Park Hill, North Little Rock.

Secretary: Sybil Ruth Rose, 104 N. Woodrow, Apt. 6, Little Rock.

Sponsor: Eva Dodge, M.D., University of Arkansas School of Medicine, Little Rock.

BAYLOR UNIVERSITY

President: Elizabeth Muchmore, 1903 Portsmouth, Houston, Texas.

Secretary: Betsy Comstock, Baylor University College of Medicine, Houston, Texas.

Sponsor: Ruth Hartgraves, M.D., 1208 The Medical Towers, Houston 25, Texas.

ESTHER C. MARTING JUNIOR BRANCH, CINCINNATI, OHIO

President: Cornelia Dettmer, 2291 Werk Rd.

Secretary: Virginia Beamer, 351 Erkendrecher Ave.

Sponsor: Esther C. Marting, M.D., 2314 Auburn Ave.

MEDICAL COLLEGE OF GEORGIA

President: Nelle Strozier, Medical College of Georgia, University Place, Augusta.

Secretary: Sara L. Goolsby, Medical College of Georgia, University Place, Augusta.

Sponsor: B. Shannon Gallaher, M.D., Medical College of Georgia, University Place, Augusta.

HAHNEMANN MEDICAL COLLEGE

President: Audrey Krauss, 300 S. Camas St., Philadelphia.

Secretary: Mary Rorro, Hahnemann Medical College, Philadelphia.

Sponsor: Elizabeth B. Brown, M.D., 1930 Chestnut St., Philadelphia.

HOWARD UNIVERSITY

President: Sara Ewell, Wheatley Hall, Howard University, Washington, D.C.

Secretary: Z. Ozella Thompson, 5345 Bell Place, Washington 1, D.C.

NORTHWESTERN UNIVERSITY

President: Marianne Whowell, 2118 N. Sedgwick, Chicago.

Secretary: Frances Taylor, 1160 N. State Street, Chicago.

Sponsor: Beulah Cushman, M.D., 25 E. Washington, Chicago.

FLORENCE SABIN JUNIOR BRANCH, UNIVERSITY OF COLORADO

President: Marcia Frances Currey, 4200 Ninth Ave., Denver.

Secretary: Olga Letitia Miskowiec, 4200 Ninth Ave., Denver.

Sponsor: Gertrud Weiss, M.D., 4200 E. Ninth Ave., Denver 20.

UNIVERSITY OF UTAH

President: Frances R. Beier, 3396 East 3900 South, Salt Lake City.

Secretary: Mary Gehres, 233 Douglas St., Salt Lake City.

Sponsor: Camilla Anderson, M.D., 239 Virginia St., Salt Lake City.

GEORGE WASHINGTON UNIVERSITY

President: Roberte Raymond, 2010 Kalorama Rd., N.W., Washington, D.C.

Secretary: Diane Perrine, 2010 Kalorama Rd., N.W., Washington, D.C.

Sponsor: Elizabeth S. Kahler, M.D., 3828 Fulton St., N.W., Washington, D.C.

UNIVERSITY OF NEBRASKA

President: Gretchen Glode, Immanuel Hospital, 34th and Forbes, Omaha.

Secretary: Marilyn Myers, 3220 Lafayette, Omaha.

Sponsor: Mary Jo Henn, M.D., University of Nebraska, College of Medicine, 42nd and Dewey Ave., Omaha.

NEBRASKA—CREIGHTON

President: Corinne Farrell, 4016 Izard St., Omaha.

Secretary: Barbara Kenyon, 4016 Izard St., Omaha.

Beginner

It isn't right to be likened to a kite, but this boy is in the soft, white clouds. He likes today and doesn't fret about tomorrow. All he wants is to get somewhere now.

First things first for this tyro, he's training for the grand flight ahead. Yes, he's a master, faster beginner. He is an S-M-A baby.

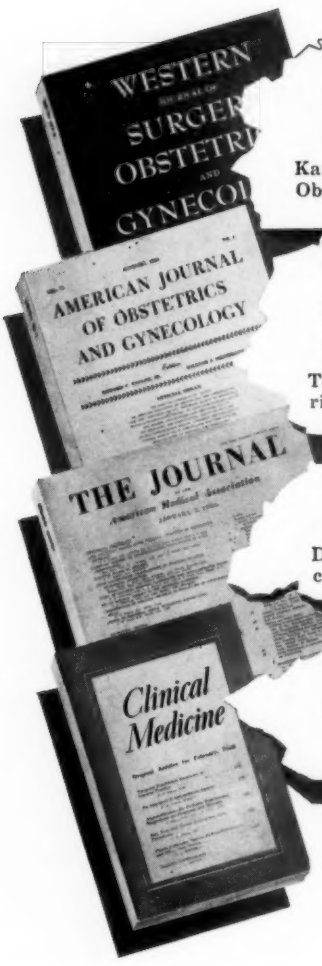
Sound Infant Nutrition

Wyeth®
Philadelphia 1, Pa.

S-M-A®
Concentrated Liquid
Instant Powder

TAMPAX

a clinically accepted method of menstrual hygiene



"Free from harm or irritation to the vaginal and cervical mucosa."

Karnaky, K. J.: Western Journal of Surgery, Obstetrics and Gynecology, Vol. 51, pp. 150-152.

"No evidence that the use of the tampon caused obstruction to menstrual flow."

Thornton, M. J.: American Journal of Obstetrics and Gynecology, Vol. 46, pp. 259-265.

"Does not impair standard anatomic virginity."

Dickinson, R. L.: The Journal of the American Medical Association, Vol. 128, pp. 490-494.

"Easy and comfortable to use and eliminated odor."

Sackren, H. S.: Clinical Medicine, Vol. 46, pp. 327-329.

Three absorbencies: Junior, Regular, or Super Tampax meet varying requirements.

TAMPAX

Professional samples and reprints of these papers furnished on request.

Tampax Incorporated, Palmer, Massachusetts

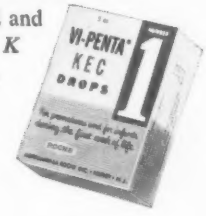
the new

VI-PENTA® FAMILY

progressive vitamin therapy

FOR PREMATURES AND INFANTS IN THE FIRST WEEK OF LIFE

Vi-Penta #1—Just 0.6 cc daily supplies vitamins K, E and C to help correct common deficiencies at birth. *Vitamin K* reduces the incidence of neonatal hemorrhage . . . *vitamin C* is always effective in abolishing hydroxyphenyluria in prematures. Supplied in 5 cc bottles.

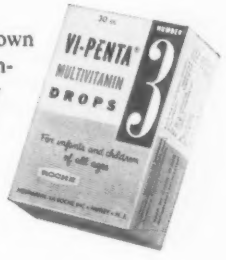


FOR INFANTS IN THE FIRST YEAR OF LIFE

Vi-Penta #2—Just 0.6 cc daily provides — in optimum amounts—vitamins A, D, C and E, especially important in the first year of life. When B factors are desired, Vi-Penta #3 may be used. Supplied in 15 cc and 50 cc bottles.

FOR INFANTS AND CHILDREN OF ALL AGES

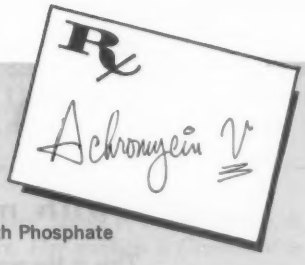
Vi-Penta #3—Just 0.6 cc daily of the original well-known Vi-Penta formula provides the full complement of 8 important vitamins children need for normal growth. Only the name has been changed; the formula and flavor remain the same. Supplied in 15 cc, 30 cc and 50 cc bottles.



ROCHE

HOFFMANN-LA ROCHE INC • NUTLEY • N. J.

V stands for— • **greater antibiotic absorption** • **earlier therapeutic blood levels** • **faster broad-spectrum action.** ACHROMYCIN V Capsules are the new, rapid-acting, oral form of ACHROMYCIN* Tetracycline—offering your patients, on the average, twice the antibiotic absorption in half the time required by older preparations.



REMEMBER THE V WHEN SPECIFYING

ACHROMYCIN® V Tetracycline Buffered with Phosphate

CAPSULES—Each capsule (pink) contains tetracycline equivalent to 250 mg. of tetracycline HCl, phosphate-buffered. Bottles of 16 and 100 capsules.

SYRUP—Each teaspoonful (5 cc.) of orange-flavored syrup contains 125 mg. of tetracycline HCl activity, phosphate-buffered. Bottles of 2 and 16 fl. oz.

ACHROMYCIN V dosage: 6-7 mg. per lb. of body weight per day for children and adults.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

Lederle

®Reg. U. S. Pat. Off.

a way of escape
from allergic effects of pollen

CO-PYRONIL

(Pyrrobutamine Compound, Lilly)

—with minimal side-effects

This is the season when we all yearn for escape from everyday life, to "commune with nature." But, to the one allergic to pollen, this craving is usually easier to endure than the penalty of exposure to pollen.

Such a patient is grateful for the relief and protection provided by 'Co-Pyronil.' Frequently, only two or three pulvules daily afford maximal beneficial effects.

'Co-Pyronil' combines the complementary actions of a rapid-acting antihistaminic, a long-acting antihistaminic, and a sympathomimetic.

Supplied: *Pulvules, pediatric pulvules, and suspension.*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

75801C

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 12 JUNE 1957 NUMBER 6

Symposium On Disease and Aging*

Claire F. Ryder, M.D.: Moderator
Marian W. Ropes, M.D.: Arthritis
Langdon Parsons, M.D.: Cancer
Priscilla White, M.D.: Diabetes
Robert T. Monroe, M.D.: Geriatrics

THE MODERATOR WAS INTRODUCED by Dr. Mermod.

Dr. Ryder: We thought that today we would try to cover some of the problems that are facing all the physicians of the United States, namely, chronic diseases in an aging population. I think it is rather ironic that the advances made in medical science and in public health have created a problem that is far worse than the problems they have eradicated. But since we have created it, I think it is our responsibility to do something about it. Today we are going to have a discussion of chronic disease from the experts, with emphasis on some of the practical aspects and measures that can be taken in helping to curb these illnesses. I would like to introduce those taking part in this symposium: Starting over on my far left is Dr. Priscilla White from the Joslin Clinic; next to me is Dr. Robert Monroe, Director of the Pearl Memorial Geriatric Clinic at the Peter Bent Brigham Hospital; on my right is Dr. Langdon Parsons, Professor of Gynecology at Boston University School of Medicine and Chief of Gynecology at the Massachusetts General Hospital;

Single copies of this symposium are available from the Chief, Chronic Disease Program, U.S. Public Health Service, Washington 25, D.C.

* Presented at the AMWA Board of Directors Meeting, Nov. 9, 1956, Boston, Mass.

Dr. Ryder, Lecturer on Gerontology in the Harvard School of Public Health, is presently Senior Surgeon (R) in the U.S. Public Health Service. Her position is Consultant in Training and Education for the Chronic Disease Program.

Dr. Ropes is Associate Physician in Medicine at Massachusetts General Hospital and Assistant Clinical Professor in Medicine at Harvard Medical School.

Dr. Parsons is Professor of Gynecology at the Boston University School of Medicine and Chief of Gynecology at Massachusetts General Hospital.

Dr. White is on the staff of the Joslin Clinic; Physician at the New England Deaconess Hospital; Associate Physician at Faulkner Hospital and Boston Lying-in Hospital; Consultant Physician at Boston Floating Hospital and New England Hospital for Women; and is on the teaching faculty of Tufts College Medical School and Harvard Medical School.

Dr. Monroe is Associate in Medicine at Harvard Medical School and Peter Bent Brigham Hospital; Director of the Pearl Memorial Geriatric Clinic; and Vice-President of the Age Center of New England.

and at my far right is Dr. Marian Ropes who is Assistant Physician in Medicine at Massachusetts General Hospital.

I think that we will start with Dr. Ropes. Her particular area of interest is arthritis. Dr. Ropes, would you start?

Dr. Ropes: Whenever I talk about arthritis, I realize that I have to point out that there are 40 kinds and maybe more. It is appropriate to start with diagnosis of arthritis, I think, because the problem of diagnosis is really one of the major problems at any age. Almost all of the 40 kinds persist into old age or start in old age. This is particularly true of degenerative joint disease.

In one sense, degenerative joint disease is not an arthritis; there is no actual inflammation in the joint in general, except in a few rare cases. But it surely is a joint disease and one that may be very troublesome. Interestingly enough, it starts at about the age of 20. Histologically one can see the first changes in the cartilage when the patient is 20 years old; at about 40, the x-ray changes ordinarily begin to appear; and, then, at about 60 years, the symptoms begin to appear. However, x-ray changes occur in something like 100 per cent of people, whereas joint symptoms occur in a very small percentage. We all differ as to what the percentage is. I think it is only a small percentage (maybe only 10 per cent or less have symptoms from their degenerative joint disease), but every single person eventually gets degenerative joint disease, since it is a natural aging process. The nature of it is not entirely understood. We assume that the same change that takes place in the ground substance of connective tissue everywhere also takes place in cartilage; then, with use, the joints react to the aging cartilage, resulting in degenerative joint disease. Probably the biggest danger in relation to degenerative joint disease is the tendency of almost every physician to ascribe all joint symptoms to these very impressive x-ray changes. Far too often, patients come to us with what is pretty obviously rheumatoid arthritis that is being treated and considered as only degenerative joint disease. These patients have been told that their x-rays show arthritis when what is meant is that their x-rays show degenerative changes—a very different thing. X-rays do not show arthritis, except when they show swelling in the joint, such as in the capsule of finger joints, or marked swelling that can be seen clinically anyway. They do show degenerative changes, such as lipping on the end of the bones, and these changes are very impressive, usually satisfying the physician and the patient (if he or she happens to see the x-ray pictures) as adequate reason for the symptoms. Unfortunately, this often means that the other joint disease that is present and responsible for the symptoms is not recognized and not treated.

Therefore, I would say that the importance of degenerative joint disease in the treatment of older people in general is not to ascribe symptoms to x-ray changes. I do not mean in any sense that degenerative joint disease does not give symptoms, particularly in its acute form. For example, acute Heberden's nodes are extremely painful and troublesome; the nodes are red and swollen, but the condition subsides. In malum coxae senilis, which we think is a degenerative joint disease, the symptoms are often severe.

In considering arthritides this afternoon, I thought that I would mention only three other types of arthritis, perhaps the most important types of disease in older people.

The first, although not the most important, is infectious arthritis, in which there is an actual organism in the joint. This is a relatively rare disease; I mention it because I think it is becoming more common. For perhaps the past five years I had seen only 1 or 2 cases of infectious arthritis; in the past four months I have seen 6, several of them in older people. I do not know what this means. I do not know whether this is another example of various organisms becoming resistant to antibiotics and then being able to metastasize to the joint. In any event, in our hospital we are seeing cases of it again, and unless one thinks of it one is not going to make the proper diagnosis, as we have discovered much to our chagrin in the past six months. One should obviously think of it when there is an acute onset of swelling, redness, and pain in a joint, particularly if there is a chill (a chill is very rare in any other kind of joint disease). The diagnosis can also be proved relatively easily by tapping the joint and by culturing the organism if possible, or by testing with antibiotics, choosing an antibiotic with wide coverage, if one does not succeed in culturing the organism out of the joint. Therefore, although infectious arthritis is rare, it is important in regard to the joints of older people.

Gout is another type, but this is not so rare—not nearly so rare as most of us thought. However, it surely is rare in women. We see very little and very little is reported in women, but in men it is quite common. As you know, joint symptoms do not occur usually until one is 45, and then they usually occur more commonly thereafter. Of course, the patient has had gout all of his life, but the joint symptoms do not begin until then. Again, if one does not think of gout one is apt to miss it,

but if one thinks of it when seeing a red, hot, swollen joint it is relatively easy to prove by determining the uric acid blood level or by finding urates in a tophus. This disease should be treated with colchicine, if effective. Butazolidin, which is also very effective in gout, unfortunately is more toxic than colchicine.

The third type of arthritis that I would like to mention today is obviously one of the most important joint diseases of old age—rheumatoid arthritis. It can start at any age. Much to the surprise of some people one of my oldest patients got it at the age of 82 and was quite well by the time he reached 84. He had a typical attack of rheumatoid arthritis, with swelling of all the midphalangeal joints, wrists, and elbows, and was quite sick systemically for almost a year; he improved during the subsequent year and did very well. Some of us think that the course of rheumatoid arthritis is not as bad in older people and in children as it is in middle-aged people; however, the statistical evidence for this is not very good. In any event, it occurs in older people and has to be treated in exactly the same way as in the middle-aged persons. There are two points about rheumatoid arthritis that I would like to mention at this moment. The first is that we have become more aware in the past few years that it is a very generalized disease; more and more evidence has accumulated that almost every system in the body is involved. In contrast to degenerative joint disease, which is just a disease of the joints—in one sense an aging and wearing out of the joints—rheumatoid arthritis is a general disease that clinically manifests itself most prominently in the joints but involves every system. The second point is our increasing awareness that it is not as severe and crippling a disease in all cases as was originally thought, or as people still tend to think. Most of us feel that perhaps only 5 to 15 per cent of patients with rheumatoid arthritis develop real progressive crippling. This seems to hold for all ages, and the percentage might even be smaller in the older age groups. At least 15 per cent, and in some series 25 per cent, get entirely well from their rheumatoid arthritis. There is another big group (perhaps 40 per cent of our patients) who do very well, if we include those who take a long time to get well. The only trouble is that it takes them so long to do so. Physicians, when following patients for six months who have not done very well in that time, think that they will never improve. One patient informed me, after seven years, that she had never believed what I said seven years before when I told her she might get well. She had been well and working for four years when she told me this, but it did take her three years to get over a very severe attack. It is a long, slow process but at least 50 per cent in any series, and probably 75 per cent with arthritis of less than one year's duration, are improved or have a complete remission.

So, in summary, I would like to point out that practically all joint diseases may occur in old age and that perhaps the biggest danger in old age is to ascribe too many symptoms to degenerative changes that are shown by x-rays, thereby missing the other joint diseases, particularly rheumatoid arthritis. The one other point I would like to stress is that rheumatoid arthritis at all ages is a reversible disease in a large percentage of cases and that this may be even more true in the older age group.

Dr. Ryder: Thank you very much, Dr. Ropes. I was very impressed with one statement you made, which was that it was difficult to distinguish between the natural process of aging and disease. I think this has been a problem facing a lot of pathologists. Is arteriosclerosis a disease, or is it just a natural wearing out of the tissues? I think that your statement also brings out the negative attitude of some individuals today toward the older person and toward chronic diseases that do occur, and that is that aging is inevitable so why do anything about it. I think that Dr. Parsons has something to say about that in regard to cancer. Would you agree with the statement that since aging is inevitable we might just as well not do anything about it?

Dr. Parsons: No. I think that applies to the whole problem of cancer work and helps to make people afraid of it. If you do make that decision and treat cancer in such a manner, it rapidly influences the whole cancer detection program. There is often a mental block not only on the part of the patient but also in the physician as well so that the diagnosis of malignant disease is usually arrived at by exclusion of all benign causes rather than by going directly to the most lethal and the most important cause.

Dr. Ryder: Would you say more about the idea of doing something about cancer? What about the problem of cancer in older persons?

Dr. Parsons: Well, I do not think that there is any doubt that this problem is going to be increasingly important as we go along, as you well know. The statistics certainly show that the mean length of life has been increasing rather markedly since 1900. At that time the expectancy was about 50 years; now it is about 68 years; and projected into the future, the average length of life will be about

71 years in 1975. About all this means is that man is coming to live to a ripe old age and that we are approaching that state we were guaranteed in the Bible of three score and ten years. It also is evident, I think, that most forms of malignant disease, with the possible exception of cancer in the ovary or testicle, increase as we progress into older age and that we are going to see more and more cancer problems. I believe that we will have to revise some of our present thinking in regard to the possibility of surgery in this older age group. I do not think that we are justified any longer in withholding surgery from these patients nor do I think that we should offer less than the optimum ideal for the patient simply because he is not as good a risk as he or she might have been at the age of 40. I do not think that we can just sit by assuming that one of the associated degenerative diseases will kill him before cancer catches up with him. We have to learn to care for these patients. Now, is this an impossible assignment? Can we do anything by surgical intervention for older patients who have malignant disease? I think we can. Take, for example, cancer of the stomach. I think that perhaps the older patient with cancer of the stomach may stand a better chance in resection than some of the younger patients. The reason for this, in all probability, is that the tumor may grow at a slower rate and metastases occur later and less readily in the older patient. Dr. Marshall of the Lahey Clinic gathered statistics on about 400 patients who had resection of the stomach for cancer, and he found that it was possible to resect the growth twice as often in patients over 60 than in those under 60. The same fact is evident in other cancers such as cancer of the rectum, but unfortunately is balanced, although to some extent not completely by the fact that older patients minimize symptoms and appear for definitive treatment later in the course of the disease. In this group an operation was rarely considered as a possibility in the past. Now, you can find increasing numbers of patients who have had abdominal perineal resection in their eighties who have been able not only to survive their operations but to live happy and useful lives afterward. (It is not enough to operate on them and have them survive unless they have some excuse for existence after operation.)

These are two instances of internal forms of malignant disease. When you consider some of the external forms of malignant disease such as cancer of the breast or vulva, the results are even more rewarding. Of course, the risks of surgery in the external forms of malignant disease are in no way comparable with those requiring intra-abdominal surgery, and the results really are encouraging.

I think by now we have established the fact that these elderly patients can withstand extensive surgery under ideal conditions very well indeed. The real problem, as I see it, is selection of suitable patients for operations, which, I hope, are designed to be curative. We also have an obligation to the patient to make him comfortable as well, but I prefer to approach a malignant disease with the idea of cure rather than of palliation. An example of this is surgery on the gastrointestinal tract in the presence of obstruction. I think that more and more resections of the primary growth are being done rather than the short-circuiting palliative type of operation, even in the presence of a few metastases. This is true of both cancer of the stomach and colon. The former attitude of trying to do a short-circuiting operation, just because the surgeon thought the patient was not going to live very long anyhow, does not hold in the present generation. But the selection of the patient has to be on an individual basis. However, what I would like to know regarding this whole problem is when does the patient get old? Who is the old patient? Every time I see the word "sixty" in literature as applied to old, I become angry. When do these senile changes affect organs adversely so that you get a poorly functioning organ? I think in the selection of patients it is more likely that the degree of cardio-vascular-renal impairment is the thing on which to determine operability rather than the chronological age of the patient. We know that many of these patients of chronologically advanced years are biologically very young patients. There is something tough about patients who live to be 70 or 80 years old. They have earned the right to live longer, and, as I frequently have said, it seems to be true that they will stand surgery that a younger patient would not tolerate at all well. The problem then comes down to the evaluation of these patients in the preoperative stage. An older patient who is properly prepared and managed goes through surgery just as well as a younger patient. There is nothing different about the technique of the actual surgery. It is just a question of adequate preoperative work-up, careful management during surgery, and postoperative care; the choice of anesthesia and the rest will add up to a successful result.

I do not think there is any place for the defeatist attitude in the approach to this problem. There is already a defeatist attitude in connection with treatment of the aged, and this is compounded as soon as you add the word cancer to it. I think

that we have to alter that point of view. On the other hand, I do not think that we can approach this problem lightly either, because the older patient, just like the child, does not have the physiological reserve that the younger adult patient has. The response of this patient to stresses is not going to be quite as forceful or sharp as you would like to have it. Usually this patient does not have just one disease; there are other complicating diseases and disabilities that go along with it. Much of the basic pathology that you have to contend with is obviously irreversible, and you cannot do anything about it. You ought to know, for instance, before you approach the problem of surgery in this group just how much hypertension there is, how much renal impairment, and what degree of arteriosclerosis is present. For example, the impairment of kidney function probably takes place in the tubules rather than in the glomeruli, which means that these patients are not able to concentrate urine and also tend to lose base. All these things are important in postoperative convalescence and in the handling of the surgery. Most patients who can concentrate urine, even though they have mild kidney disease, are able to withstand both anesthesia and surgery pretty well. It is important to know the degree of the impairment for another reason. If infection appears in this picture and antibiotics must be used, indiscriminate use of the broad-spectrum antibiotics may cause trouble, because the toxic effect of some of these antibiotics is on the tubules. You cannot change the basic tubular pathology at all, but you must evaluate it if you are going to manage the older patients properly. It is also important that we know a little bit about the past history. No longer do we worry about healed coronary heart disease. We do not worry about bundle branch block. We do not worry about auricular fibrillation if it can be controlled. We *are* interested in acute myocardial damage or in the arrhythmias that cannot be controlled. Certain complications and deficiencies we have spoken about are definitely correctable. For example, in cases of carcinoma of the lung there may also be bronchiectasis and lung infection. You can do a great deal for that patient in preparing him for surgery—by postural drainage, by use of antibiotics, or, in other words, by getting him in shape so as to reduce the possibility of complications in the postoperative field. The same thing goes for oral sepsis. I think one of the hardest things regarding the problem of age and cancer is the combination of malnutrition, negative nitrogen balance, and probably a low blood volume. These are important factors to control. The hormonal output is also somewhat reduced. For that reason I think it may be helpful to use Depo-Testosterone. There were some interesting experiments reported at a meeting of the American College of Surgeons recently in which they were able to build up and keep patients nourished and reduce the amount of nitrogen loss by the use of Depo-Testosterone. You get a better utilization of the diet the patient can tolerate. You also can do a lot for cardiac decompensation, for instance, by use of digitalis and mercurial diuretics before operation. A word about blood volume is fitting here. There is a practical point that I would like to make because it has some use. How do you determine blood volume? The determination of blood volume is important in preparing these patients for surgery, since it may determine whether surgery should be attempted. We know that these patients cannot stand shock or hemorrhage at all well. I think it is pretty obvious that the arterial system is not as elastic as it was earlier and cannot stand these stresses or expand and adapt itself to changes in blood volume and blood pressure. The veins tend to pool the blood in the body. The patients do not tolerate a hypotensive level for any length of time before getting into serious trouble. There may be a point at which we have to replace blood in a hurry, and it is important to know what the blood volume was previously. There are many disadvantages, at least theoretically, in trying to transfuse an older patient. We are always afraid of overloading his cardiovascular system and producing pulmonary edema or cardiac failure. As a rule of thumb you can probably do more good by the use of transfusions in improving the circulation than in embarrassing it by giving too much blood, provided you give it slowly. If we only knew what the extent of that blood volume was before we started and did not have to replace the blood under stress in emergencies, we would be on much sounder ground. Now how are we going to be able to do that? You cannot tell very well from the hemoglobins, hematocrit readings, and other laboratory studies of that type. If you were in an institution where you could perform an Evan's blue dye test or tag the red blood cells and determine blood volume in that way, it would be very helpful; but, there are not many institutions where that sort of laboratory help is available. So, what are we going to do? Somebody has come up with a rule of thumb that a number of my cohorts, who know a good deal regarding it, say works out very well. The rule of thumb is: by using the normal weight of the patient according to standard tables for age, height, and weight and allowing for obesity,

and then replacing the blood at the rate of 40 cc. for every pound of weight loss, you will come very close to replacing the blood volume to its normal level, with very little danger of creating an oversupply, so to speak. With this practice you are better able to handle the emergencies that develop in the course of surgery.

Dr. Ryder: Very interesting. One thing that I think has become very apparent is that someone has defined disease in the older person as being characterized by three factors: chronicity, multiplicity, and duplicity. This has been pointed out very nicely. Dr. White was telling us at lunch that she is very enthusiastic and very ready to talk about new developments in the therapy of older patients with diabetes. We will hear from her now.

Dr. White: As the other speakers have brought out, in the aging population we too have met the problems of the aged diabetic. Numerically, 10 per cent of our diabetics have their onset after the age of 70, and interestingly enough this is the identical number who have an onset of diabetes in childhood. In the older age group there are twice as many diabetic women as diabetic men. The standards and criteria for diagnosis in this older group are the same as in young patients. We accept hyperglycemia and glycosuria as diagnostic, and, using the new values (those of true glucose in the presence of glycosuria), we would make the diagnosis if the fasting blood sugar were 110 mg. per 100 cc., the postprandial venous blood 150 mg. per 100 cc., or the postprandial capillary blood sugar 180 mg. per 100 cc. If one measures severity of diabetes by the insulin requirement, contrary to what is usually said, many of these older diabetics have a severe form of the disease. A dose of 100 units of insulin daily is not at all uncommon. At the present time we have a new tool for classifying diabetics, and, we think, for measuring the severity of their illness. This tool is evaluation of their response to the oral substitute or the sulfonylurea drugs. If we define as satisfactory a fall of blood sugar of 20 mg. per 100 cc. in four hours after the administration of 3 Gm. of these drugs, the striking failures have been in the juvenile and elderly patients. In the younger patients we attribute the severity of their disease to growth and development, and my guess is that the severity in the older patients is probably due to the extensive vascular changes of the pancreas. Younger patients frequently run a favorable early course, which we designate a remission. In the older population we rarely see a temporary remission of diabetes. The complications we associate with the disease—increased susceptibility to infections, diabetic neuropathies, vascular damage, and diabetic coma—show the following frequencies in this elderly group: Infections and neuropathies occur with the same frequencies as they do in the general diabetic population. A quarter have had infections, largely urinary tract infections, skin infections, or osteomyelitis, and one-fifth have had neuropathies. The whole picture of tabes can be seen in a typical diabetic neuropathy. Conspicuous differences in the diabetic population are shown, however, by the infrequent occurrence of diabetic coma in older patients and by the characteristics and distribution of vascular manifestations. These older patients, who comprise 10 per cent of our diabetics were represented by only 2 per cent in our coma series, whereas the juveniles, who also comprise 10 per cent of our diabetics, were represented by 40 per cent in the coma series. Cardiovascular damage is, of course, common as one would suppose. Peripheral vascular damage occurs in about one third of the older patients, and these patients tolerate surgery well. Cerebrovascular damage occurs in a fifth, but, contrary to experience with young diabetics who have renal and retinal involvement, the elderly diabetic has a reasonably good retina. Retinopathy occurs in only a fifth of the cases and is not the retinopathy characteristic of diabetes (it is not venular but arteriolar in type, more as one sees in hypertensive patients). In the early report of the nephropathy of diabetes, the Kimmelsteil-Wilson syndrome, it was thought that this lesion was a characteristic finding in the older diabetic with a mild case. Today we know that this is not true; this is the characteristic lesion of the juvenile diabetic, and few older patients, some 5 per cent with nephropathy, are apt to have arteriolar nephrosclerosis.

The treatment of elderly patients consists largely of regulation of their diet, insulin therapy or the oral substitute, and, of course, diabetic education. Formerly we taught that the elderly diabetic should have a rather markedly restricted diet, perhaps not more than 20 calories per Kg. of body weight, but as time has gone on we have found that they tolerate more calories and not only tolerate them but demand them. And so, they are fed almost like active adults. There are several philosophies about the dietary treatment of diabetes, but we do believe in regulation and therefore restrict the carbohydrate to about half the normal quantity. We try to give adequate protein. Many of these patients, as I have suggested before, do require insulin, and we favor use of one of the intermediate acting insulins (globin, NPH, or lente). Although these often work better mixed with rapidly acting in-

sulin, technically this is difficult to do, and so, with this older group, we try to give them just a simple, single type of insulin. We test them for the oral substitute and usually start therapy with 3 Gm. of BZ55 or Orinase (six tablets) before breakfast. Within a week the dose usually is reduced to .25 to 1 Gm. (half to two tablets) given just before breakfast. The standard of a normal blood sugar level is sometimes difficult to achieve in these patients because they do tend to have high kidney thresholds for glucose and because control is difficult. With their senile changes they do forget to take insulin or the oral substitute and they often forget completely the rules about their diet.

This small case I am carrying, which is really a cosmetic case, contains all the things really necessary for the treatment, and perhaps for the laboratory procedures in management, of the diabetic patient today. There is the oral substitute, a rapidly acting insulin for emergencies, one of the intermediate acting insulins (lente), and a simple test tape (Tes-Tape) with which the urine is placed in contact for two minutes (the directions say one), allowing percentage of sugar to be quickly noted. A blood sugar tape, on which one drop of blood records the blood sugar level in three minutes, is not on the market yet. In screening with this tape the values are from 50 to 125, 125 to 250, 250 to 350 mg. per 100 cc., and above, but often all one really wants to know is whether the blood sugar level is low, average, or high. One would not do scientific research or diagnosis with it. This tape is very helpful for the patient as well as for the physician. More and more the management of diabetes in all age groups is becoming quite simple and practical.

Dr. Ryder: Thank you very much Dr. White. We have had a forecasting of things to come. I think one of the things that has been stressed right straight through is the fact that each patient is an individual: individual in terms of treatment and diagnosis. Also we are talking about the whole patient, not about treating him for a single disease and ignoring what else may be present. I know that I am stealing some of Dr. Monroe's thunder when I say this, but I have learned it from his lips so I think I am perfectly safe in saying it. But now I would like to hear some of your ideas about the geriatric patient, Dr. Monroe, and the things about which we should be conscious and aware.

Dr. Monroe: When Dr. Ryder asked me a few weeks ago to talk at this meeting, I asked her what she wanted me to talk about. She said, "Give your philosophy." I resented that at first until I began to think that in the olden days the philosopher was the one who actually knew everything—all sciences and everything else. Of course, nowadays all scientists are split off from each other and are no longer philosophers. The situation of the philosopher is very much like that of the general practitioner who goes on learning less and less about more and more. In fact, I am a philosopher in that sense, being now a specialist in everything. There is a lot of fun in approaching old people that way because it involves a different point of view, which could be summarized by saying that every older person must be recognized as an individual in spite of his illness and in spite of his age. The corollary to that idea is that symptom or disease-oriented medicine is not enough. The patient may come to you with a symptom or disease, which is his ticket of admission. He may wish or appear to wish to have that symptom taken care of, but the geriatrician has to be alert to what the patient is not telling him but what he would like to tell him if he thought the geriatrician was worth being told. You can get into all sorts of entrancing situations in taking care of old people. You have to be patient, give your eyes a rest at times, and remember that things "ain't so bad as they seem." They are bad. All old people have chronic disease, 100 per cent squeaks, and "rheumatics" (or whatever you want to call it), confirmed by x-rays and sometimes made worse when they are confirmed by x-rays, particularly if the doctor has also accepted the diagnosis that the radiologist has made. All old people have skin changes, and 80 per cent have some sort of heart affection. Most of these patients have high blood pressure some or most of the time, and most of them probably have diverticula of the bowels. It is the exciting combination of these affairs that makes geriatric medicine interesting. When a person comes into the hospital with a coronary occlusion, we wonder if he is going to have a cerebral occlusion as well. Or did the cerebral occlusion come first and produce the coronary occlusion? Or did the two combine and produce a gastric hemorrhage from his old ulcer? What happens to his varicose veins when he is left resting quietly in bed? What happens to this patient who remains an individual in spite of what you and the nurses are trying to do to his disease? It is a matter of sitting on dynamite and whistling.

If you find high blood pressure and you are a young doctor, you let a certain sign of worry, surprise, or fear creep into your face, and the pressure goes up. You have to stop and consider that the high blood pressure was probably there before you put the instrument on. If the patient is able to walk into your office or into the clinic and seems

to be in reasonably good shape, maybe you had better keep still until you decide whether or not to pay attention to the high blood pressure. You certainly should not rush into depressor drugs just because he has something that shows up on the blood pressure machine. They do not help old people very often. In the first place, malignant hypertension practically does not occur in people over 65. I am not sure that I ever saw a headache in an older person due to high blood pressure, though I have seen many mental headaches due to high blood pressure. I have been able to cure a certain amount of blood pressure symptoms by stopping use of the blood pressure pills the patients were taking. So many of these pills are cerebral depressants. All of us old people begin to think we are losing our minds or memory or that the physician will think so. Then we are given a chemical depressant and we have to work harder to keep what we think we are losing. Then we get more depressed, our blood pressure goes up, and we take more high blood pressure pills. This attitude applies also to the very common aortic systolic murmur, which can be very annoyingly loud at times. If it goes with a narrow pulse pressure, the physician is sure that there is aortic stenosis. Then, the patient is in for trouble in case the pulmonary pressure increases, such as with a cold. If there is a high pulse pressure you say it is aortic sclerosis, as if you had said something, and you worry about that patient and he sees you worry because of his murmur. If some intelligent doctor has told him that he has one, he says, "Well, doctor, don't worry about that. I've had that murmur for a long time." The attitude goes down all along the line. If you hear about rheumatic squeaks, aches, and pains and find the arthritis, well, all right, he problably has that, just like he has the knobs on his fingers. What does the ache and pain mean to him? Maybe you can cure him by telling him that they are a sign of wear and tear of ordinary trauma, and perhaps by better use and not being too frantic about curing the patient with the most rapidly acting, radio-advertised aspirin, he will get along fine.

Of the several main points I would like to make, the first is that most old people are normal (certainly in their own minds they are, and in certain areas they really are). It is like Katisha in the Mikado who had lost certain attractions but who was sure that men would come miles to see her left shoulder. We are all normal, even though we may be sick. Sickness is an incident and is temporary. Statistics bear this out. I hate statistics. I hate to look at old people as a mass, but when you put them all together only 5 per cent of people more than 65 years of age are in institutions of any sort, including mental institutions, nursing homes, and chronic hospitals—only 5 per cent. If you look at economic surveys you will be told how many, many old people are indigent, are in want, and are in need of housing. Then you look at the other side of the picture and you find by and large that the majority are not in want and are still economically and socially independent.

Another interesting thing is that older people have a decent life expectancy, and that is more or less true regardless of their disease. If a man has reached 70 years, in spite of what you think you are going to find in him, particularly if he has a cancer that is going to be taken care of, he has an expectancy of around 10 years. As far as he is concerned those are very important years, probably better than the 20 years he thinks you have left. If he reaches 90 years he still has a few years to live, and they are interesting to him.

Another general point is that most diseases in old people are just diseases in any people and are not specific for old people. They respond to ordinary treatment. There is one disease, however, that may be a little different in older persons, and that is the ordinary chronic grippe (virus respiratory infection). When you get that, you know how in the recovery period, which always takes weeks or months, there are times when you feel quite sorry for yourself and feel depressed and tired. When you get old, you say, "That's my age. I'm slowing up. I'm losing my mind. I'm getting depressed. Depression is cerebral arteriosclerosis." If you as a physician are smart enough to see that this is a virus respiratory infection that is still hanging on, you have done more for your patient than you may realize.

In planning care of old people (and only a few of them may want simply their symptoms to be taken care of) there are things that they need to know about themselves that we must tell them. One is that they have to work harder to keep their physical fitness than younger people do. I do not know what physical fitness is. It is hard to measure it, but it is easy to see the lack of it in older people. You see it as some reason for their demineralized bones, for their poorly performing muscles, and for their squeaky joints, particularly if they are unfortunate enough in their old age to maintain double and loose joints. It certainly is the basis for a great deal of the motor indigestion you see and for a lack of zest in life. I think it has a lot to do with poor balance and poor co-ordination. There is some evidence that a good many hips are broken by feeble old people. Their bones are fragile, but the

bone breaks first and then the patient falls, rather than the patient earning a fracture by the trauma of falling. Also there is more than average need for these old people to watch their nutritional fitness, which implies more than just knowledge of what a good diet is. It is a good many years of learned habits about what the diet must be. Some of it is medically induced. You have to be sharp to see that the person who once was treated for heart disease or high blood pressure at some time is told that it is all right to stop going without salt, that it is all right for him to go back cautiously to fruit or to milk, or that in spite of his age it is all right to take meat. There is a lot of medically induced malnutrition I suspect. A good diet is nothing, however, unless there is some reason for eating, which is often absent in old people. A lack of social fitness colors a certain amount of behavior and disease; that is very common. In regard to mental fitness in older patients, only 10 per cent, at the most, have organic brain damage. Most of our poor mental fitness is well earned by the way we behave and study. These things have a very great bearing on how a person stands up to disease, how he stands up to his doctor, and how he stands up to what is ahead of him. We can make some of these things better. We can make some of them worse, if we are too scientific or too pressurized with them. Maybe you can order children around, but you cannot order old people around. You have to wait for their co-operation and their understanding, and these take time. It takes some time for me to understand what they do not understand. That is why I sometimes develop ideas not quite according to Hoyle about how our interns should be taught medicine.

Dr. Ryder: Thank you Dr. Monroe. I was very happy to have Dr. Monroe bring out the fact, of which public health people are so conscious, that only 5 per cent, or less than 5 per cent, of the older persons are actually institutionalized and that we really have to worry about the 95 per cent who are out in the community. Would the panel like to discuss what we can do with the 95 per cent? How can we help them to keep well? What kind of preventive measures should we be advocating to our older patients? Dr. Monroe has brought out quite a few points about fitness. What about fitness in the specific areas of arthritis, cancer, diabetes, and so on? Dr. Ropes, what would you suggest as far as arthritis is concerned?

Dr. Ropes: I am trying to think of things Dr. Monroe has not said. The points that he has made are the most important. There is no question that helping patients with the approach described by Dr. Monroe aids most in the handling of their disease. I think people of all ages need this same problem pointed out to them in terms of what their difficulties are, particularly emotionally. The things they would like to say if they dared and the things they hope we will discover about them are usually much more important to them than their physical difficulty alone, be it due to organic disease or to the particular load they carry. I think that handling this in older persons merely means an appreciation of the difference in their load and of the fact that so few of them have learned to change the way they handle their load as it has changed. Although I do not know when old age begins, I find it easiest to tell people that they will have to change the way they handle their load, because their life is changing, when they are between 35 and 55. This varies according to the situation and the period when the biggest changes occur. My handling of the arthritic patient is usually such that he or she asks: "Are you a psychiatrist?" I spend a great deal of time trying to find out what the loads are, why patients cannot handle them, and why they do not even know that they are loads. This is the same in the older age group, but, in general, older patients find it a little harder to realize that they can shift. "I'm too old to learn" is so commonly said. I do not refer to learning in the study sense but rather to learning different approaches, different interests, and different handling. Once they are persuaded that they are never too old to do the kind of things we advise, I find them to be better off.

Dr. Ryder: At lunch, Dr. Parsons, you mentioned that certain advice was being given to people about preventing cancer. What are your thoughts on this idea? Are there certain steps that we should take? How do you feel about it?

Dr. Parsons: To go back again to this delay factor in diagnosis, if we could get across to the patient, without increasing his fear of malignant disease, that there is a possibility we can do something for him in all phases of malignant disease, I think we would accomplish a great deal. In some of our propaganda work we stress too much the factor of early diagnosis, which, of course, is enormously important but which does keep us from giving help to patients who may not be in the early stages of the disease. I think that we have built up the idea of early diagnosis so much that it boomerangs a little bit. Patients say: "Perhaps mine isn't the early form of the disease and therefore they won't be able to do anything about it. I don't want to know anything about it, and I will avoid treatment just as long as I have to." In the older age groups that idea becomes more and more pro-

nounced, particularly if these patients are discouraged about their lot and do not think they have much of a future anyhow. I think the medical profession is guilty too, because in their approach to the patient with malignant disease there comes not despair or disinterest but a lack of giving hope to the patient that something can be done for him. I am perfectly sure that is wrong and that some of our instruction has gone too far along that line.

I do not know when old age begins. I was fascinated by some figures showing that perhaps aging is a process that goes on all through life. Interesting to me were figures showing the incidence of coronary disease in soldiers who died or were killed in Korea. Autopsies showed that a surprising number of these men, who were in their twenties and thirties, had coronary artery disease. Well then, coronary disease is not a disease peculiar to old age; it is something that you gradually build up to, and it goes through the whole life span. I do not think that those men would have liked to be called aging patients at that point, but evidently they were.

Dr. Ryder: I guess *we* are the aging in other words. This idea also points out the lack of correlation sometimes between the clinical findings and the actual disease. In other words, as Dr. Ropes pointed out, many of these patients with x-ray changes are symptom-free, and we therefore should not always rely entirely on the laboratory for our diagnosis. Dr. Monroe, you have seen that the older person frequently equates activity with health rather than with the presence of disease. Is that not true?

Dr. Monroe: I think there are certain statistics that suggest there is as much disease in the people who take care of old people as there is in the people of whom they take care. You brought up an interesting point. How do we go after health? I am sure we cannot preach health, although we would love to. How do we get people to exercise who think that they should not? "At my age I must go slow." "Is it right for me at my age to like to play?" Play does more for the patient than work does, because he gets better co-ordination and releases tensions if he plays. "Is it right for me to enjoy myself and do anything more than look like Whistler's Mother?" The trouble with preaching is that we have to preach only to the people who come to us, who are people with symptoms, disease, or both. Having had a sudden insight a little while ago that we doctors are awfully myopic or monoptic and talk about all disease on the basis of what we see in our hospital or in our practice, it suddenly occurred to me that, after all, few people really *do* go to hospitals or to doctors. Perhaps the way to study health in old people is to go after the healthy ones, that is, the ones who do not come to us. More or less on that ridiculous basis, we gradually put together the Age Center of New England, which is not a service center. A great many interesting people are turning up there—normal, independent, aging people. We try to get notes from their doctors, if they have them, but a lot of them do not have doctors. We are trying to get some idea of whether these members really are as normal mentally and physically in the presence or absence of disease as they say they are. That is an interesting medical exercise in itself. The fact is that a number of these people who are gradually coming out and exposing themselves to a research situation are normal. And, I do not think normalcy has anything to do with the presence or absence of pathological processes. Most of us consider ourselves normal. "Of course, I have a little arthritis; I've had a coronary; I had an ulcer; but I'm normal; I'm healthy." I do not think there are any standards for what is healthy.

Dr. Ryder: It is hard to define health. Dr. White, what would you say your advice would be to older patients, or rather to older healthy individuals.

Dr. White: My experience has not been quite so great, since after all my concern is quite the opposite. The premature aging of the young individual is my challenging problem. Remember that in diabetes one of the great problems is the extensive change in the vascular tree, so that I am inclined to think of my patients when they are 35 as being more like individuals of 70.

Dr. Ryder: How about the relationship between diet, obesity, and diabetes?

Dr. White: In the older population obesity certainly is one of the predisposing factors. Eight out of every 10 individuals who develop diabetes have been overweight, and many of the serious complications are in those who have been most overweight. That, however, plays no part in what we consider pure diabetes, which is seen in the younger person.

Dr. Ryder: Are you implying therefore that there are different kinds of diabetes?

Dr. White: It may be a matter of degree.

Dr. Ryder: Are there any questions from members of the audience?

From audience: How soon will the testing tape be on the market?

Dr. White: Very soon I think. The urine test tape was tested clinically about three months before it went on the market, and this has been in our laboratory now for about two weeks. In about eight weeks more it should be on the market.

From audience: I am very interested in the study of the health of older people. How extensive is your

study, Dr. Monroe, and when will the facts from the study you are conducting at the Age Center be available? Will these facts be of general use?

Dr. Monroe: We are still figuring out what we are finding. We are setting up exercise groups, play groups, and volunteer work groups and watching the effects of work and play on symptoms, nutrition, and high blood pressure. The whole study is a long-range observation. We have no figures available as yet from the Age Center as to what these things mean. There are about 350 members there so far. A considerable number of them actually seem to have escaped hospitals or disease. I have not answered the question; indeed, I am still trying to define it.

Dr. Ryder: I have always been impressed with the relationship between work and health. (I mean the broad definition of work—something to do—whether it is paid employment or volunteer work.) This was brought out yesterday when I was discussing a television program for next Sunday, which involves a group of members from the Age Center. Yesterday we were talking over what areas should be covered by the panel, and I was very impressed with the importance of this relationship as seen by the older person. It was almost as if we were talking about which came first—the chicken or the egg. In other words, the panelists felt that work was necessary to keep healthy and that it was necessary to keep healthy in order to go on working. Take away one or the other and you throw the person off balance. I wonder if that is not true in any of these diseases. Is it true, Dr. Ropes, that a person with severe arthritis, for example, if kept busy can ignore many symptoms that would otherwise put him into bed?

Dr. Ropes: Surely, and the person we are most disturbed about, whatever the age, is the person who is unable to carry on life despite limitations—the one who uses illness as the only means of adjustment. I am sure that is true in many cases of the older person who uses his aging changes, which are natural and which should not necessarily cause symptoms, as his way of adjusting—I mean unconsciously and without any sense of malingering at the time. This is a real problem in a disease like arthritis, because inflammatory disease demands treatment of the patient as a whole and a great deal of rest. The problem is: when is the rest period rightly over and when should the patient begin to take on more active work? I agree entirely with Dr. Ryder that a satisfying activity is essential throughout the duration of the disease. In fact one of my favorite questions to a patient is: "What is it that you are getting well for?" If they are not able to tell me anything specifically except that they want to get back to work, I point out to them that I do not expect them to get well until they can tell me for what they are getting well.

From audience: Do you have any suggestions as to prevention or treatment in degenerative joint disease?

Dr. Ropes: I think degenerative joint disease is a universal disease in the sense of the changes that take place in the tissue. We wish we knew what the tissue change was. We assume that it is some enzymatic change that affects the matrix. Actually the polysaccharides and proteins in cartilage are in different proportion if you measure them in older aged patients. I think the alteration in the tissue is a normal change in the sense that everyone has to go through it, but I surely do not think symptoms have to come from it. Symptoms from degenerative joint disease are relatively rare and can be prevented often by avoiding traumatizing overuse. We saw one woman, a cutter at a factory, who developed degenerative joint disease at the age of 40 in just one joint she constantly used. When she took another job she had no more symptoms. Of course, she had degenerative joint disease but she developed symptoms of it at 40 only from overuse. Our feeling is that one should reduce weight so as not to traumatize the weight-bearing joints and that one should reduce excessive and abnormal use of one joint. It is our feeling that the changes are normal and will do no harm in general unless we wrongly use the joint, except in the two types of disease I have previously mentioned (Heberden's nodes and malum coxae senilis). We do not understand these and can merely treat them after they develop. Also, the principle of treating with some antispasmodic immediately when spasm appears—for instance, when pain comes and the patient is suppressing normal motions—seems to help. I think that aspirin and heat help a great deal in allowing normal use.

Dr. Ryder: One area of prevention that has been brought out in the papers a great deal is the question of smoking and lung cancer. I just asked Dr. Parsons if I could dare to query him about it.

Dr. Parsons: There is no question about the fact that you can work out a statistical background of smog and smoking as contributing factors to development of lung cancer, but I do not think that everybody who smokes is going to get lung cancer. That is true of so many other things in relation to malignant disease. We speak of the relation of the hormones. We know that the hormones (the ovarian hormone, for example) stimulate and produce epithelial growth. We know that if you give

enough estrogen you can produce in the endometrial lining an actual hyperplasia by the use of estrogen. We know that we use many hormones and that many women have hyperplasia of the endometrium as the cause of their bleeding, but they are relatively few when you come to think of it in relation to the amount of hormones indiscriminately used and passed over the counter with the "do good" pills. But, since there are relatively few cases of cancer of the endometrium, there has to be some other genetic factor, some other organ, or some other stimulating factor that makes the patient who has hyperplasia of the endometrium develop malignant disease. The same thing undoubtedly holds for cancer of the lung. As I told you awhile ago, at one meeting I attended, a discussion was carried on all afternoon regarding the various forms of malignant disease. I found that if I smoked I would get cancer of the lung. If I enjoyed alcohol or ate spicy foods I would get cancer of the stomach or of the liver. If a woman had many children she was bound to have cancer of the cervix and uterus. When they finished I was scheduled to talk. Since everything I liked to do was evidently very bad for me, and since I would develop malignant disease if I pursued my habits, I thought that perhaps the public would not be any more interested in giving up these things than I was and that therefore there would always be cancer. I asked, therefore, whether they would mind if I talked on the early detection of cancer.

Dr. Ryder: What would be your advice to an older person, Dr. Monroe, if he asked you a question about smoking?

Dr. Monroe: I would tell him it was sinful and if he liked sin he could have it. I am a little bit stronger about alcohol. I advise it a little bit more strongly than I do smoking. It is one of the best sedatives there is. In reasonable doses it causes little hang-over the next day. It does warm up the extremities. It does stop real interesting activity with your worries. It should be taken for fun and not as a medicine.

I would like to say a word about sleeping poorly. This is such an interesting thing to study in old people. They seem to think they should sleep badly or that they always have slept badly, and in retirement they have more time to think about it. If you get interested in their problem and say that there are a number of sedatives to try and to keep on trying them, the insomnia persists and the mental performance may get worse, or the patient starts going somewhere else for his insomnia pills. The last patient I had, just yesterday morning in the clinic, was a man who had tried everything for his insomnia in the last 10 years since he had retired. Nothing seemed to work. I asked: "What time do you go to bed?" "Ten o'clock." "What time do you wake up?" "Six o'clock. I can't sleep after six." "But are not eight hours enough?"

Dr. Ryder: Dr. Parsons seems to want to speak.

Dr. Parsons: I have been impressed by the patient's discouragement toward the problem of aging. This discouragement seems to influence many of the disease processes and focuses on them. I wonder if a part of this at least is because we confuse and mix up very definitely the reproductive function with that of the aging process. When the menopause or the male climacteric, or whatever you want to call it, comes into being, the adrenal takes over and puts out androgen and estrogen, therefore virtually making us neuters. Inasmuch as in our early years we are bisexual (up to the age of 10), if we add the 25 years we expect to live after menopause or the climateric, 35 years, or nearly half of our allotted time on earth, are spent as a neuter. I wonder if all these organs are as dead as we think they are or whether the ovary, the thyroid, and the adrenal perhaps still function. I would like to think that at least the ovary continues to function well into the seventies or longer. We have become accustomed to think that just because it does not have enough power to turn over an endometrium or produce an egg that it is an atrophied, dead, and useless organ. I do not believe this, and, if we could encourage the general public with that idea, perhaps some of the depression about getting old, which has no real relation to the reproductive problem, would lessen. That is a controversial question and will possibly start a fight.

Dr. Ryder: I do not know that it will. It seems that everyone is in agreement with that.

From audience: It is interesting that there are so many schools of thought on the preservation of ovarian function in women. That is always a good topic for discussion. What is the age at which you would remove one or both ovaries, but mostly both, if you were operating on the abdomen for another type of pathological lesion? Some are of the opinion that ovarian conservation should be maintained after the patient is 40 or 45 years because of the so-called continuing activity of the ovary. On the other hand, there are those who say that one out of every 100 women who reach the age of 40 will develop ovarian carcinoma and that, therefore, from the standpoint of prevention at the time of surgery for other pathological lesions in the pelvis, it would be wise to take out the ovaries. How do you feel about it?

Dr. Parsons: Oh! Regarding malignant disease, if you remember rightly I made a statement earlier today that with advancing years most forms of malignant disease seem to increase except for two. One was ovary and one was testicle. If you follow any large series of these cases a peak is developed when the patients are 55 and then it tends to drop off in that way. I think that most of these ovarian or testicular carcinomas are developmental in origin and that if they have not manifested development at the time you are inspecting and looking at them (when the patient is in the forties, or at some time thereafter), they are not likely to in the subsequent menopausal period. In fact, the people who advocate removing the ovaries do not do it any longer on the basis of carcinoma developing in the retained ovary. I believe that those ovaries function. Up to now we have not been able to prove it, because we have had to go to urinary assays of the various ovarian hormones that may be produced in the adrenal or another source. Recently we have tried to incubate ovaries to find out if they actually had a production in this period. So many of these ovaries show stromal hyperplasia, which is mixed up with the production of estrogen. Regarding heart disease, some of the figures from the Mayo Clinic show that fatal coronary heart disease in women is almost unheard of and that when it is present it is always in a patient who has had her ovaries removed. There is a great deal of clinical evidence to prove that the ovaries function. Perhaps two thirds of the ovaries in women in Dr. Summer's series still show evidence of stromal hyperplasia in the menopausal period; in other words, they are functioning. We do not know what the element is in the estrogen progress that they are producing. We do not know whether it is one of the estrones, estradiol, or estriol. We are just too dull or too dumb, and our laboratory evidence has not kept pace with this thing. It is a hard and complex problem. I think eventually we will partition that estrogen factor and will find out which one is active. I have a theme song: "The ovary has been very good to me. In youth it protected me, and I'll protect it now."

Dr. Ryder: I think the subject of how we measure the aging of tissues is a very important one in studying the aspects of gerontology that we have been talking about today. Dr. Nathan Shock, who is with the Public Health Service, is conducting various research projects at Baltimore City Hospital, and he was telling us one time at a meeting that in all the tests that they have been able to do with normal, healthy, older individuals there was nothing that the 95 year old person could not do if he had been able to do it previously. These tests were in terms of renal function and dietary uptake of vitamins and in terms of arterial functions and so forth. He further defined these older people as normal, healthy individuals. Then he would get stuck when he was asked: "How do you know when aging has occurred, if the person can respond to all of these tests in a normal fashion? What is disease? What is aging? And what does happen when the function does go down? Is it disease, or is it aging?" He pointed out that many things we previously called disease are now being called normal processes of aging. Previously we thought of arteriosclerosis as a disease. Now that we find so many people have it, we begin to wonder if it is normal. Should degenerative joint disease now be called normal? This is our real problem—deciding what is going on with the aging process—and it points up the need for research. Are there any other questions or remarks from the audience?

From audience: Dr. Monroe, do you know of any work that is going on regarding reversing of arteriosclerosis?

Dr. Monroe: I do not know of anything specifically. Dr. Irving Page in Indianapolis has done some of that; at least he is seeing some reversed changes in hypertensive retinopathies, the disappearance of which is in response to certain therapies (dietary or drug). As for arteriosclerosis, I do not know of anything. Being a general practitioner I doubt the diagnosis of generalized arteriosclerosis, which any house officer is willing to make as soon as the person comes into the room. I have only 1 case that I really would call generalized arteriosclerosis —in a 62 year old man who has had one anterior coronary infarct and who recovered after three weeks in the hospital. He has had an operation for a vascular occlusion in the leg with intermittent claudication, and he has had a little occipital stroke involving a portion of his vision. The only interesting thing about this patient is that, except for three weeks in the hospital once and 10 days another time, he has been at work, has produced a new business, plays golf, and is the mainstay of a pretty big business that he developed. He has generalized arteriosclerosis, at least in three areas. I do not know specifically how much these hard arteries, which one sees on x-rays, and which one can feel, interfere with function. I am opposed to altering diet to produce better arterial function. Even if you could decrease the cholesterol in these sclerotic pipes by reducing the cholesterol in food, you might produce a hemorrhage or a break in the artery at that point. If you have hard arteries you

better keep on eating all the butter, milk, and eggs you can to keep strong.

Dr. Parsons: You can give them a balanced diet of estrone and alcohol.

Dr. Ryder: I thought I saw another hand up for a question.

From audience: May I go back and ask Dr. Parsons if he believes in preserving the ovaries when there is carcinoma of the breast?

Dr. Parsons: That is a tough one. I could go into quite a long discussion about that. I do not know if anybody has ever proved that subsequent development of carcinoma could be prevented in a patient who has not demonstrated metastases, for instance. Perhaps, we are too eager to take out ovaries when there is cancer of the breast. I think again we have an individual to consider. Some young girls do not like to be mutilated and resent the operation almost more than any other operation because it does represent mutilation. They are already upset by the fact that they have a malignant disease, and, then, if you put the castration phenomena on top of that, I think you have to have very good evidence that you are going to prevent development of carcinoma in that opposite breast or prevent spread of metastases. On the other hand, if there are metastases, I think that removal of the ovary should be done, with subsequent use of cortisone along with it. If you plan to use that kind of hormone therapy, it does depend pretty largely on the removal of that ovary. There you have good evidence. For the sake of prevention, however, I do not think there is sufficient proof. You can reduce your patient to a 5 per cent vegetable, but whether you prolong life is something else again.

From audience: I would like to ask Dr. White her opinion of what she thinks of Clinistix in comparison to Tes-Tape.

Dr. White: I think it depends upon the age of the patients you see. For the average adult and the older patient, I think the Tes-Tape is fine, but it just tells you three things: Yellow is perfect, all the shades of green are good, and blue is terrible. With juveniles, I prefer Clinitest because the color gradations are better (there are five or six different values with Clinitest). The different colors on Tes-Tape are just a little bit apart: one-tenth, two-tenths, three-tenths, fourth-tenths, and then a jump to 2 per cent, which for the older patient is all right because he does not have as much sugar.

From audience: I mean Clinistix.

Dr. White: I consider both useful in screening.

Dr. Ryder: Are there any last remarks that the panel would like to make? Any other questions?

I would like to say that I thoroughly enjoyed sitting in on this panel. I have gotten a great deal out of it. I am sure I can speak for the audience too in thanking you all. I would like to point out that we have covered a vast amount of material today, and that some of the points are obvious and have come out often. These are that older people are individuals; that they have acute as well as chronic disease; and that they have combinations of these and multiplicity of disease. I think also that we can not stop at finding the disease but have to think of the whole individual. We must think of the social factors, the psychological factors, and the economic factors. And, also, because of this, as physicians, we have to be very careful not to create iatrogenic disease. Does it matter so much if the blood pressure is up? Is this really disease or not? There are many signs that are universal, and there seems to be a lack of correlation between the sign and the actual symptom. I think that we have to agree that aging is with us, that we are all aging, and that, if we believe what Dr. Monroe says, we will all end up with some chronic disease at some time or another. However, prevention is a factor here. I like to think of prevention as being a very broad thing. I remember hearing a definition that prevention can go on until rigor mortis sets in. I think that the final thing I would like to say, which has also been expressed by several members of the panel, is that our goal is not medicated survival but really seeing to it that the older individual has a fuller and a more worth-while life—something to look forward to. Thank you very much.

Sigmund Freud: To the One Hundredth Anniversary of his Birth*

Heinrich Meng, M.D.

Authorized Translation from the German by Ada Dunner, M.D.

A GREAT DEAL has been written about Sigmund Freud, favorably as well as unfavorably. While the hundredth anniversary of his birth (May 6, 1856) offers the opportunity to add something of value to the physician, this task creates a twofold problem. Not many physicians have read the works of Freud, and even fewer have practiced his method of therapy. For those who are only vaguely familiar with him it will not be easy to form a real and objective picture of either his work or of the man himself from a brief memorial article. The other thought is: how would Freud view the task that is to be undertaken here? From occasional conversations that I had with him, I conclude that he might perhaps say: "In describing my life's work, please consider what is clinically certain and what, on the other hand, is merely speculation," or, as he once said, "vision."

Sigmund Freud, the best student during the seven year course of the *Gymnasium,* before he received his B.A. degree, had directed his interests principally toward humanistic, cultural, and philosophical problems. During the winter of 1872, just as he was about to register for the study of law and political science, he was asked by a friend to do a newspaper report on the first anatomy lecture by Professor Brühl. Freud was so deeply impressed by the lecture, particularly by the aphoristically quoted "Ode an die Natur" (ascribed to Goethe at that time), that he decided to study medicine.

During his university studies and after his state board examinations, Freud devoted himself primarily to experimental and microscopic investigations, especially in the fields of anatomy of the nervous system, physiology, and biology. In this period of his life belong also his studies on cocaine, which caused him to assume that cocaine had anesthetic effects on the eye. The assumption was later confirmed by C. Koller, who was acquainted with Freud's preliminary findings.

Especially stimulated by Brücke and Meynert, in whose laboratories Freud did research from 1876 to 1882, he devoted his interest mainly to problems of pathology of the brain. In experiments of his own, he re-examined the anatomic, physiological, and clinical foundations of the theories on local anesthesia of Griesinger, Wernicke (aphasia chart), and Meynert (equating of cerebral anatomy with physiology). In 1888 and 1891 he published his criticisms of the aphasia theory of Wernicke-Lichtheim and Meynert. Darwin's theory of evolution as applied to the nervous system fascinated him. In his theoretical treatises in which he refuted the theories of localization, he was an adherent of Hughlings Jackson, believing that nervous illnesses are to be understood genetically as a regression from developed functions to earlier and more primitive ones.

Freud was the first in Vienna to diagnose an acute polyneuritis; the exact localization in the nervous system determined by him was later confirmed during autopsy. His publications on hemi-

*Published originally in "Ciba-Symposium," in Basel, Switzerland, on Feb. 4, 1956, under the title of "Sigmund Freud zum 100. Geburtstag."

Dr. Meng, an eminent European psychoanalyst, is Professor of Psychohygiene, Department of Medicine, University of Basel.

Dr. Dunner, a graduate of the University of Basel, practices psychotherapy in Des Moines, Iowa; is Consultant to Family Service—Travelers Aid and to Iowa Children's Home Society and is on the attending staffs of Iowa Methodist Hospital, Hillcrest Hospital, and Broadlawns Polk County Hospital. She is President of Branch Nineteen (Iowa) of AMWA for 1957.

plegias, chorea, hemianopsia, infantile paralysis, and aphasia, to quote but a few titles, are to this day considered classics. In 1885 Freud became special lecturer of neuropathology at the University of Vienna. In early May, 1886, he opened his practice in Vienna. In 1902 he became full professor in the Department of Medicine of the University of Vienna.

His meeting in Brücke's laboratory with J. Breuer, the internist, physiologist, and researcher in hypnosis, his stay in Paris with Charcot, and his stay with Bernheim and Liébault convinced Freud of the importance of psychogenesis in the dynamics and structure of hysteria as well as in the artificially and hypnotically produced pseudohysteria. During his sojourn in France and in his contacts with Breuer, there matured in the neurologist Freud an insight and a way of cognition which later permitted him to find the fundamentals of psychoanalysis.

The critical objections that Freud already raised during the beginning stages of the classical theory of localization against the main concepts of "projection and association" permit one to recognize his endeavor to lead from the statically rigid compulsion of the anatomic schematic diagram of the brain toward a more mobile functional order. This endeavor can be seen especially from a speculative draft that attempts to formulate the concepts of "representation" and functional regression of a harmonious apparatus of speech. In this attempt the ideas and concepts of the British neurologist Hughlings Jackson offered decisive assistance.

Freud implemented this transformation in three separate steps to which he devoted three "studies." The step of the motor apparatus is followed by the step of the apparatus of speech, which is to be conceived of as one of memory. From this last step the development leads finally to psychoanalysis.

In studying hypnotism, especially Breuer's cathartic method with hysterical patients, Freud experienced insight into the significance of disturbed affective life in the formation of symptoms. There dawned in him the recognition that emotional life was accessible to our understanding only by way of the emotions and that psychic factors had to be treated by psychological means. Freud had found proof, which could be demonstrated clinically, that there was an "unconscious." One must distinguish between acts that are unconscious and acts that are capable of becoming conscious. The fact of conversion (of psychological energies into the somatic) and the possibility of abreaction (the affective release of falsely utilized and dammed-up energies) were clinically established certainties.

It is generally known that Breuer and Freud separated as far as theoretical research and therapy are concerned after having collaborated for years in the application of the hypnotic-cathartic method. Apart from different interpretations of phenomena, Freud's assumption that the abnormal affective situation of the hysteric was predominantly of sexual genesis led him to go his own ways. ("I was not prepared for this result; my expectation had no part in this; I had approached the study of the neurotic without any preconceived ideas.") Based upon his observations of the development of emotional conflicts ensuing between sexual drive, ego, and conscience, and of the effects that these conflicts have, Freud constructed his theory of repression. He no longer used hypnosis. He asked rather that his patients "free-associate" in the waking state. His procedure developed from a merely cathartic to a psychoanalytic one. In gathering the facts of the early life of his patients he noted the importance of infantile sexual seduction in childhood, a theory he later altered. The neurotic symptoms are rarely connected with real life events; rather, they are primarily connected with wishful fantasies. It is the psychological reality that is of decisive importance.

It would lead us too far afield to penetrate in detail into the elements of psychoanalysis which Freud called the unconscious, transference, repression, slips, resistance, Oedipus and castration complex, interpretation of dreams, infantile sexuality, and libido. In the course of decades of psychoanalytic work these elements became the starting points of repeated clinical re-evaluation of unbiased and frequently also of biased criticism. For the understanding of the diseased and the healthy life of body and psyche, Freud's findings of the unconscious, the dream, transference, slips, secondary gain, flight into illness, amnesia, health conscience, anxiety, repression, and sublimation have proved to be significant in anthropology, psychopathology, and therapy. Freud created the foundations of a new science of sex, an ego and instinct psychology founded upon a depth-psychological basis. But Freud, the scientific investigator and therapist, always emphasized that these were only preliminary studies. He never rested on his findings; he was always disquieted by all problems that needed further investigation. He revised his first theory of the drives and the ego, self-preservation and hunger on one hand and the libidinal drives (love) on the other. He changed it in the light of the new theory of the love and death instinct—all this in keeping with his constant endeavor to re-evaluate his theories and hypotheses and to mod-

ify and alter these theories and hypotheses if it was necessary.

The milestones in the evolution of Freudian psychology which have been acting as ferments for the entire field of medicine and for the practice of psychotherapy are predominantly the following: (1) interpretation of dreams; ("The dream is the royal road to the unconscious.") (2) clinical evalution of psychoanalysis, especially with reference to the investigation of schizophrenias; (In this respect the research of E. Bleuler and C. G. Jung [1906] was the determining impetus.) (3) the development of a psychonanalytic ego psychology ("Zur Einführing des Narzissmus" in 1914); (4) the formulation of the new theory of instincts ("Jenseits des Lustprinzips" in 1920); and (5) revision of individual clinical and theoretical points of view, especially expansion and a more solid foundation of a new theory of anxiety ("Hemmung, Symptom, und Angst" in 1926).

We are not as yet in a position to make final judgments about the effect of Freud's teachings upon the medicine of the future. Nevertheless, in view of the impact that Freud's ideas have had so far on medicine and especially on medical specialties, we can point out that Freud has produced a change in the thinking of the physicians and has discovered a new way of looking at medical phenomena. A shift of emphasis has taken place in the evaluation of the significance of the formation, content, and therapy of an illness. New bases for obtaining and utilizing the anamneses have evolved, the preconditions of an etiological and firmly constructed theory of the neuroses and their therapy. Freud created a clinically productive medical psychology through the teachings of the unconscious, conflict, and anxiety. He analyzed the distant effect of experiences, predominantly of the first six years of life, and the influences of the latency period and puberty upon character formation and the premorbid personality structure. Through his new methods of perceiving and understanding he broke the ground for the clarification of formerly impenetrable diagnostic and therapeutic problems, especially problems of so-called psychosomatic origin. He furthermore made possible a clarification of the motivation and the meaning of illness and the interpretation of the biography and of the environmental constellation of the sick person. The development of psychiatry and child psychiatry stand under the sign of the evaluation and continued development of Freudian empiricism, especially as far as questions of genesis and therapy of the neuroses, the schizophrenias, the character anomalies, forensic psychiatry and prophylaxis, and prevention of crime are concerned. The same is true for preventive psychiatry and for preventive medicine.

A critical review of Freud's work must be based upon factual argumentation if it is to be taken seriously. To such criticism Freud never objected. "Psychoanalysis feels its way forward along the path of experience; it is always incomplete; it is always prepared to adjust or modify its teachings. . . . It expects a sharper delineation of its premises from future work."

A frequently discussed topic is the assumption that Freud fell victim to pansexualism. This is not a fact. Among others, Ludwig Binswanger, in utilizing Freud's findings, has established that a well-informed student of psychoanalysis would have to contradict this contention most sharply. The misunderstanding is probably in part due to the fact that Freud was the first to investigate biologically the powerful effect that human sexuality has. Then, however, followed a period in which Freud directed his attention just as intensely to the counterparts of the sexual drive, the ego and the conscience. Perhaps in the beginning he may have put too much emphasis upon sexuality, but the last decades of his work demonstrated how receptive he was to the clarification of nonsexual human concerns. In the unproductive battle between the two, formerly between sex and ego and later between eros and the death instinct, Freud saw the nucleus of neurotic illness of man at any age and of either sex in the struggle with the demands of civilization.

My first meeting with the Viennese scientist took place in 1919 shortly after the end of World War II. I was face to face with a man who reminded me strongly of a type frequently seen in brilliant French scholars, similar to the great Pasteur, whom, as I learned later, Freud revered very much. In conversation Freud used sharp logic. He made no compromise in his search for truth; he did not tolerate hypocrisy, untruthfulness, or superstition. With humility and without vanity he spoke of his life's work. The sharpness of his critical thinking and his sarcasm when discussing friend or foe did not stand in contradiction to the sincerity of his character. The sharpness of his point of view was softened by his sense of humor. When in 1933 we spoke about his books being burned publicly in Germany, he said: "Such progress! In the Middle Ages they would have burnt me; today they are satisfied with burning my writings."

Striking was Freud's mental alertness in conversations following a long day of work. Karl Abraham states that after hours of visiting museums during a trip to Italy, Freud would pursue his sci-

entific interests in the evening, apparently without any signs of fatigue.

At the beginning of his psychoanalytic research Freud was almost completely isolated; physicians, with very few exceptions, were skeptical or hostile to him. Later, the picture changed. This change, to which no doubt Bleuler's and Jung's defense of psychoanalysis has contributed, is probably due to Freud's truly impressive personality.

During the last decades before Freud's death, honors from the scientific world were manifold. During this period he was given the Goethe prize by the city of Frankfurt on the Main (1930).

In 1938 Freud had to emigrate from Vienna; on Sept. 23, 1939, he died in London. For 16 years he had battled against a malignant tumor without losing interest in the affairs of the world, except for the two days preceding his death. Also, he did not give up his practice until 1939.

It is not too important to medical science of the future whether this or that theory of Freud's will be abandoned or modified. What is of value is that physicians and psychologists really learn to know his findings through study of the original source materials and that they utilize them in the service of preventive medicine and therapy.

Bibliography

Bernfeld, S.: Freud's earliest theories and school of Helmholtz, Psychoanalyt. Quart. **13:** 341-362, July, 1944.

Bernfeld, S.: Freud's scientific beginnings, Am. Imago **6:** 163-196, 1949.

Bernfeld, S.: Sigmund Freud, M.D., 1882-1885, Internat. J. Psycho-Analysis **32:**204-217, 1951.

Binswanger, L.: Freud und die Verfassung der klinischen Psychiatrie, Schweiz. Arch. f. Neurol. u. Psychiat. **37:**177-199, 1936.

Binswanger, L.: Freud's Auffassung des Menschen im Lichte der Anthropologie, in Ausgewählte Vorträge und Aufsätze:Zur phänomenologischen Anthropologie, Bern, Francke, 1947, vol. 1, p. 159.

Brun, R.: Über biologische Psychologie, ihre wissenschaftstheoretischen Grundlagen, ihre Berechtigung und Leistungsfähigkeit, Schweiz. Ztschr. Psychol. **8:** 1-20, 1949.

Brun, R.: Allgemeine Neurosenlehre: Biologie, Psychoanalyse und Psychohygiene lieb-seelischer Störungen, ed. 3, Basel, Schwabe, 1954.

Brun, R.: Biologie, Psychologie und Psychoanalyse, Wien. Ztschr. Nervenh. **9:**333-358, 1954.

Dorer, M.: Historische Grundlagen der Psychoanalyse, Dissertation, Leipzig, Meiner, 1932.

Erikson, E. H.: Review of Sigmund Freud: "The origins of psychoanalysis." Letters to Wilhelm Fliess, Drafts and Notes; 1887-1902, Psyche **9:**30-116, April, 1955.

Federn, P., and Meng, H.: Wir lesen Freud, in Das psychoanalytische Volksbuch, ed. 5, Bern, Huber, 1956.

Freud, A.: Über bestimmte Schwierigkeiten der Elternbeziehung in der Vorpubertät, in Federn, P., and Meng, H.: Die Psychohygiene: Grundlagen und Ziele, Bein, Huber, 1949, p. 10.

Freud, S.: Gesammelte Werke. Chronologisch Geordnet, London, Imago Publishing Co., Ltd., 1941-1952, 18 volumes.

Freud, S.: Zur Auffassung der Aphasien, Leipzig and Vienna, Deuticke, 1891.

Freud, S.: Zur Kenntnis der cerebralen Diplegien des Kindesalters, Leipzig and Vienna, Deuticke, 1893.

Freud, S.: Bibliographie und Inhaltsangaben der Arbeiten Freuds bis zu den Anfängen der Psychoanalyse, Internat. Ztschr. f. Psychoanal. u. Imago **25:**69-93, 1940.

Hartmann, H.: Die Grundlagen der Psychoanalyse, Leipzig, Thieme, 1927.

Jelliffe, S. E.: Sigmund Freud as neurologist: Some notes on his earlier neurobiological and clinical neurological studies, J. Nerv. & Ment. Dis. **85:**696-711, June, 1937.

Jones, E.: Preface to Papers on Psychoanalysis, London, Baillière, Tindall and Cox, 1912.

Jones, E.: The Life and Work of Sigmund Freud: vol. 1: The Formative Years and the Great Discoveries, 1856-1900, New York, Basic Books Inc., 1953; vol. 2: Years of Maturity, 1901 to 1919, New York, Basic Books, Inc., 1955; vol. 3: in press.

Jones, E.: Freud's Early Travels, Internat. J. Psycho-Analysis **35:**81-84, 1954.

Kris, E.: Significance of Freud's earliest discoveries, Internat. J. Psycho-Analysis **31:**108-116, 1950.

Mann, T., and others: Thomas Mann und 350 Dichter, Schriftsteller und Künstler zum 80: Geburtstag von S. Freud, in Federn, P., and Meng, H.: Das psychoanalytische Volksbuch, ed. 5, Bern, Huber, 1956.

Richard G.: Psychoanalyse und Ethik, in Pfister, A.: Geistige Hygiene, Basel, Schwabe, 1955.

Riese, W.: Proceedings of the First International Congress of Psychiatry (1950), Paris, Hermann and Cie, 1952, vol. 1, p. 501.

Spehlmann, R.: Sigmund Freuds neurologische Schriften: Eine Untersuchung zur Vorgeschichte der Psychoanalyse, Berlin, Springer-Verlag, 1953.

Stengel, E.: Re-evaluation of Freud's book on aphasia: Its significance for psycho-analysis, Internat. J. Psycho-Analysis **35:**85-89, 1954.

Vogel, P.: Eine erste, unbekannt gebliebeine Darstellung der Hysterie von Sigmund Freud, Psyche **7:**483-500, Dec., 1953.

Vogel, P.: Sigmund Freuds Beitrag zur Gehirnpathologie, Psyche **9:**42-53, April, 1955.

Zilboorg, G.: Some sidelights on free associations, Internat. J. Psycho-Analysis **33:**489-495, 1952.

Main Reference Sources

Freud, S.: The standard edition of the complete psychological works of Sigmund Freud. Translated from the German under the general editorship of Strachey, S., in collaboration with Freud, A., and assisted by Strachey, A., and Tyson, A. London, Hogarth Press, 1953, 24 volumes (8 volumes published to date).

Freud, S.: Collected Papers, London, Hogarth Press, 1924-1950, vol. 1-5.

Jones, E.: The Life and Work of Sigmund Freud: vol. 1: The Formative Years and the Great Discoveries, 1856-1900, New York, Basic Books, Inc., 1953; vol. 2: Years of Maturity, 1901 to 1919, New York, Basic Books, Inc., 1955.

Women Doctors in Japan: Past and Present

Kazue Ohara, M.D.

THERE ARE MANY WOMEN in the medical field in Japan. In fact, there are as many as there are in any of the Western countries. This is because the Japanese people live crammed in a narrow space of land, where earthquakes, typhoons, fires, and pestilences are prevalent. Also, because of the high birth rate, the Japanese people need doctors.

A total of nearly 13,000 students attend the one women's medical college and the 46 coeducational medical schools of universities and medical colleges. Of this number, over 1,000 are women. Graduates from these schools now number over 100,000, of whom 11,569 are women. Many country towns now have practicing women doctors. These women have as many patients and earn as much as, if not more than, male doctors. In many hospital clinics, women doctors are on the same level as men. Women doctors number about 10 per cent of the total, but the ratio has been rising in favor of women in recent years.

Women are found in practically every kind of medical work. There are professors, associate professors, lecturers, and so forth, teaching every specialty, and doing well, but receiving less pay than the men.

HISTORICAL BACKGROUND

Looking back, we find that there were women doctors even in the mythological days. Records of this are found in the oldest Japanese book, "Kojiki," written about 2,000 years ago. Two goddesses in charge of medicine used certain kinds of clams in order to heal the god Okuninushi of his badly burned skin. Supposedly dead, the goddesses called his spirit back and revived him. Those two women doctors might have been personifications of the clams used in treating the wound.

Coming down the ages, the second oldest Japanese book, "Nihonshoki," mentions that many medical students and court ladies made a present to the emperor of various drugs and curiosities shipped from China. This is the first historical fact ever recorded about women and medicine.

The words "woman doctor" appeared first in the year 701 A.D. when an edict was issued establishing the medical education system of the state. It regulated the way medical herbs were to be cultivated and how 30 elite court women, aged 15 to 25 years, were to be educated in medicine. The whole system was divided into five divisions: the medical department, including internal medicine, surgery, pediatrics, otorhinolaryngology, and dentistry; the acupuncture department; the massage department; the incantation department; and the herb-horticulture department. The women's department was set up, independent of them all, to train women doctors. The 30 girls, clever and with good memory, were accommodated in a special house and taught, first, midwifery and child care and, then, a little surgical art on wounds and tumors. Next came treatment of sprains and broken bones and, lastly, acupuncture and "cupping." While regular medical students were given textbooks for study, the women's classes learned techniques only by listening to what the teachers recited from Chinese books. Most probably, they could not read. They had to pass an examination each month and, on top of that, a full examination at the end of the year. The whole course was finished in seven years.

It was in the year 722 A.D. that the scholastic title of "learned woman doctor," something equivalent to the M.D. title, was established. We are, however, not yet quite sure whether it was the woman doctor who was learned or whether it was

Dr. Ohara graduated from Osaka Medical School, the present Kansai Medical School, with honors. She is Associate Professor of Dermatology and Urology at Kansai Medical School. In 1956, she was chosen to represent Japanese medical women at the Council Meeting of the Medical Women's International Association in Burgenstock, Switzerland.

the man who taught a woman to become a doctor who was learned. Such ambiguity exists in the old language that it could be read in both ways: however, the fact that a medical school for women existed more than 1,200 years ago is noteworthy.

During this era, the Emperor Shomu and the Empress Komyo were known for their touching tenderness to the poor and sick. The empress built a "house of drugs" and stored medicinal herbs gathered from all over the country to be given freely to the poor. Then she built an almshouse to accommodate poor and sick people. She also built a bath house for lepers. These benevolent acts of the empress were the first recorded in Japanese history of medical service by women for the sake of public welfare. The spirit behind such acts was nurtured by Buddhism, and it came down through the ages. At about this time, a Korean woman named Kote was a Buddhist nun and also a doctor.

In the twelfth century there was another nun famous for exterminating parasitic worms, and there were several other women doctors of high literary culture. For some hundreds of years after that there were wars, revolutions, famines, extravagances, flourishings of art and literature, as in every country, and such torrential vicissitudes that anything concerning women and medicine was lost for awhile, only to be rediscovered much later in the age of the feudal lord Tokugawa Shogunate.

At the end of the seventeenth century there was a woman called Enko Nonaka, a model of love and fidelity toward her parents and ancestors. She lived a solitary, unmarried life to the age of 66. She never saw patients and never let them come near her—she only allowed them to sit in another room adjacent to hers. Between the two rooms were sliding doors kept firmly shut. Through one of those doors ran a long string, the ends of which were held by the patient in his room and the doctor in hers. After sitting in that position for awhile, she is said to have been able to diagnose how ill her patient was and with what illness. She did not let herself be seen in public but was widely known for her peculiar art of diagnosing. Another woman doctor called Sono Watarai was of fine character and of good literary taste. Many of her stanzas of "Haiku," a short poem of 17 syllables, have been handed down. Still another, Y. Morisaki, 100 years later, wrote an authoritative book on gynecology. She stood high as a scholar of pathology and had many women as well as men students. That she taught men at this time was, and is, remarkable. She and many other intellectual women were especially outstanding since, at that time, woman's intellectual training was at a low level and midwives were regarded with such esteem as to be called doctors.

In the year 1791, a medical center was established by the feudal central government. Later, many more were established by local lords all over the country. Very few women's names are known in this connection. The peculiarity of the era of the feudal Tokugawa government, which held all Japan under its control, was that it wanted to have the nation live completely secluded in the islands, having nothing to do with foreigners. Foreigners gave them too much trouble. The only way to live in peace in this world was by national seclusion—so they thought. The leaders of this government were discouraged by scores of bad entanglements in the past with Mongolians, Chinese, Dutch, Spaniards, and even Christians. They had had enough trouble, and, by shutting the doors of the country completely to all other nations and by preventing the natives from going abroad, they hoped and thought they could have a national prosperity of their own. But it was not long before they found to their dismay that the ever-swelling population was fast driving the nation in the opposite direction. More and more mouths were getting less and less rice. New generations were ever poorer than their forefathers. Fathers saw that the world was becoming a more and more unhappy place for their sons and daughters. To get themselves out of this vicious course, their last resort was abortion. The "thinning out of human sprouts" was drastic but effective.

Before long, the feudal government of Tokugawa Shogunate became alarmed. The leaders realized that the sudden diminution of the population and moral deterioration were leading the people to ruin. Several harsh decrees were made public, with no effect. So-called doctors were in demand for the sordid business of "thinning out human sprouts," and they flourished. Midwives in the guise of doctors gave a bad name to women doctors.

Before control by the Tokugawa government, medical science and art had been imported into Japan by Dutchmen. With it had come a dawn for Japan, also a dawn for Japanese women. Japan owes her knowledge of Western medicine, both pathological and clinical, originally to the Dutch. Until this time, she had known only medicinal herbs and medical art learned from China.

Miss Ine Kusumoto (1827-1893), the daughter of a Dutch physician (Siebold) and a geisha girl (Otaki) is never to be forgotten. Miss Ine, the apple of Siebold's eye, was the first Japanese

woman doctor schooled in Dutch medical science. She learned obstetrics and gynecology under Siebold's principal disciples, one of whom she married. She practiced medicine at Nagasaki and Tokyo and later became a court physician.

Some 30 years before the turn of the century, Japan went through a bloodless revolution (the Restoration) to become again an empire. Japan aspired to become a full-fledged member in international politics and in the modern world of Western science. Right after the Restoration, medical practice was put under state authority and was permitted only to those who passed a strict examination. Women could not apply for this.

Japanese women strove bitterly with zeal and sincerity, and, because of those aspiring women, what had seemed to be a stone wall finally collapsed. In the year 1885, Ginko Ogino was the first Japanese woman to pass the state board examination to become a modern woman doctor. Then came a second and a third. The third one was a pioneering woman, Zuiko Takahashi, who visited Berlin to study. Japan owes her present-day medicine chiefly to Germany. To medical students of Miss Takahashi's time, Berlin was the Mecca of medical science, and Miss Takahashi was the first Japanese woman to go on the pilgrimage. She found, however, that the door of Berlin University was shut relentlessly against her—not only against her but also against all German women as well. There was no woman doctor practicing either in Germany or in Austria. Japan was well advanced in this matter of women practicing medicine, more advanced than one of the world's most progressive countries in medical science.

At about this time, there sprang up in Tokyo several small medical schools. Mrs. Yayoi Yoshioka, who had passed the state board examination some years before, founded a small medical school for women, which sent out in the first year of graduation only one woman. This school has grown up and now has a history of 57 years as the only women's medical college in Japan. There were two other women's colleges, one in Tokyo and the other in Osaka, but both have recently become coeducational. (After World War II, when most schools of universities and colleges in the country had become coeducational, there seemed to be no reason why these two colleges should remain exclusively for women.) Every school or college has at least one woman student.

General Review of Statistics

The most reliable figures are those made available by the government welfare department. They are the compilation of all reports returned from individuals. Table I shows that the total number of doctors, men and women, was 89,885 in the year 1953; 8,390, or 9.3 per cent of the total, were women—an increase of 292 from 1952. Compared with the number of women doctors in 1950, this is an increase of 1,696 within three years; compared with the number in 1948, the increase of 2,975 show a good rate of expansion in five years.

TABLE I.
Number of Japanese Physicians

Year	Men	Women	(%)	Total
1950	69,752	6,694	(8.7)	76,446
1951	76,473	7,618	(9.1)	84,091
1952	77,276	8,098	(9.5)	85,374
1953	81,495	8,390	(9.3)	89,885

If we look back to the years before World War II, the total number of doctors was 61,799 in 1937; 3,799, or 6.1 per cent, were women. The total number of women doctors increased yearly; but, in 1942, a decrease in the total number of doctors set in, probably because men doctors were called to the front. Because of this, the percentage of women rose from 6.2 in 1941 to 9.0 in 1945; but, in the following year, 1946, the figures returned to approximate those reported before the war (yearly increases similar to those mentioned earlier in this article).

To review the figures on dentists, for comparison, of which the percentage of women is always great, 3,164, or 10.5 per cent, of 30,086 dentists in 1953 were women. Since 1950, women have numbered more than 10 per cent of the total of dentists.

Table II shows the areas of work in which women doctors are engaged. Most of them are private practitioners. Of the total for women, 39.6 per cent are in private practice; of the total for men, 48.8 per cent engage in private practice. Women doctors who work in hospitals, clinics, sanatoriums, and so forth (other than those of uni-

TABLE II.
Type of Medical Work in 1953

	Men	Women	Total
Private practice	39,319	3,326	42,645
Employed	26,409	2,978	29,387
Clinic of medical school hospital	8,945	617	9,562
Basic medicine of medical school	2,668	158	2,826
Official	2,603	526	3,129
Others	1,551	785	2,336
Total	81,495	8,390	89,885

versity hospitals and clinics) number 35.5 per cent (for men the figure is 32.5 per cent). Women on the payroll of the medical education system number 775, or 6.3 per cent (9.2 per cent of all women doctors). On the same payroll there are 14.2 per cent of all medical men. Women teachers and researchers in basic medicine, excluding those in clinics, show a poor percentage of 1.9 as against 3.3 for men. Women who are in sanitary administration or public health are 16.8 per cent of the total in these services, far below the figure for men; however, of the total number of women doctors, 6.3 per cent are in these services, nearly double the 3.2 per cent for the men.

To sum up, more women, as compared with men, are found on the payrolls of hospitals and public health organizations than in private practice or in the educational system. There are more women professors and research workers in the medical field than in any other branch of science. At Tokyo Women's Medical College, for example, there are 7 professors from among its graduates, 9 associate professors, and 13 lecturers—all women. There is also a professor from among the graduates of the Toho Medical College. In Kansai Medical College there are 12 associate professors and several lecturers. And there are many other women doctors who are on the dietetics and hygiene staffs in nonmedical schools. It is also good to find the names of women in the lists of reporters in various societies of science.

In table III, men and women doctors are listed by age groups. We see at a glance that women are more numerous in the younger age group than are men. While the number of men below 45 years of age is 62.8 per cent, that of women is 83.6 per cent. Women below age 25 are conspicuously numerous as compared with men of the same age scale.

TABLE III.
Japanese Physicians in 1953 by Age Group

Age, yr.	Men	Women	Total
20-24	724	408	1,132
25-29	17,233	2,250	19,483
30-34	13,118	1,701	14,819
35-39	9,518	1,339	10,857
40-44	10,571	1,320	11,891
45-49	8,016	625	8,641
50-54	6,174	369	6,543
55-59	4,989	168	5,157
60-64	4,204	106	4,310
65-69	3,670	56	3,726
70-74	2,105	28	2,133
75 and over	1,115	15	1,130
Unknown	58	5	63
Total	81,495	8,390	89,885

TABLE IV.
Specialties of Japanese Physicians in 1953

	Men	Women	Total
General practice	6,641	304	6,945
Internal medicine	37,915	3,259	41,174
Chest	5,305	352	5,657
Gastroenterology	2,473	144	2,617
Hematology	1,791	110	1,901
Pediatrics	20,970	2,966	23,936
Psychoneurology	1,487	110	1,597
Surgery	17,198	362	17,560
Orthopedics	3,562	77	3,639
Obstetrics and gynecology	10,619	1,226	11,845
Ophthalmology	3,787	1,247	5,034
Otorhinolaryngology.	4,880	617	5,497
Tracheoesophagology.	656	28	684
Dermatology and urology	7,108	175	7,283
Radiology	4,319	152	4,471
Proctology	1,646	39	1,685
Others	266	25	291
Total	130,623	11,193	141,816

In table IV, the numbers are divided into specialties. Women with more than one specialty are fewer in number than men. There is a greater percentage of women of the total number of women in internal medicine and general practice, followed by pediatrics, ophthalmology, and gynecology. Men are similarly more numerous in internal medicine and pediatrics, but then comes surgery, followed by gynecology, dermatology, and neurology. Tracing the ratio of women to men in the various specialties, we find that women are about one fourth (24.8 per cent) of all ophthalmologists, 12.4 per cent of pediatricians, 11.2 per cent of otorhinolaryngologists, 10.4 per cent of gynecologists, and 7.9 per cent of internists. Women surgeons are comparatively few in number and are 3.2 per cent of the total number of women doctors, with men numbering 13.1 per cent. Women dermatologists are 2.4 per cent of the total number of dermatologists; orthopedists, 2.1 per cent; rectal surgeons, 2.3 per cent; psychoneurologists, 6.9 per cent; and radiologists, 3.4 per cent. But, apart from the question of whether or not the statistical figures are high or low, the fact is that women are found in every line of clinical work and on the same level as men.

It is of interest to view the grand total of women graduates from all schools of the medical system. The Tokyo Women's Medical College is at the top and has sent out nearly 4,500 graduates to date. Including the two former women's colleges, the total amounts to 10,368. If we add to it all other graduates from medical schools, the grand total comes to 11,569 (table V).

We find that there is a disparity between this

TABLE V.
Graduates of Medical School (Aug. 1, 1956)

Type of School	Men No.	Men %	Women No.	Women %	Total
21 national	63,170	99.8	138	0.2	63,308
13 public	6,468	85.9	1,063	14.1	7,531
13 private	33,527	76.4	10,368	23.6	43,895
Total	103,165		11,569		114,734

number and that of doctors reported earlier in this paper. Even though we make some allowances for those on the obituary list, there are some discrepancies for which we cannot account. In discussion it is said that, while nearly all men remain in medical work once they have started, women often stop immediately after graduation or depart from medicine after some time.

Of all women in medicine, at the end of the year 1953, 250 had received the title of *"Igakuhakushi,"* which is the highest learned title comparable to the Ph.D. degree. This is about 1 per cent of the total of 27,800 so designated in Japan. Today, there are almost 300 women with this title. (In Japan the *"Igakuhakushi"* degree is given for clinical research and not for practice of a specialty. A graduate of a medical school in Japan is called *"Igakushi,"* which is comparable to the M.D. degree. The *"Igakuhakushi"* degree is given only to a doctor who has written several excellent articles on medical research and who has had a thorough examination from a committee of a qualified university. This usually takes from seven to eight years at least after graduation and is expensive. The Japanese *"Igakuhakushi"* degree is more authoritative than the American M.D. degree.

The first woman who received the title of *"Igakuhakushi"* was a graduate of Tokyo Medical College, and the degree was granted in 1931 by Tokyo Imperial University. It was the third doctorate given to a woman, the first and the second having been given in physics. As the years went by, the number of women *"Igakuhakushis"* increased most in the year 1945, and, after a slight decrease in rate in 1947 and 1948, the number went up again and has been rising continuously ever since. All these degrees were given by the 18 universities privileged to examine such candidates. Most were given by Tokyo University and next by Keio. There has been at least one given by each of the 18 universities. The recipients are mostly graduates from the three women's medical colleges. Miss Shigeko Fukui is the only woman who was made *"Igakuhakushi"* some years after having been qualified as a doctor by the state examination of bygone days. She is an active gynecologist and is at present Vice-President of the Japan Medical Women's Association and President of Osaka Medical Women's Association. She is an energetic woman of more than 80 years of age. The *"Igakuhakushi"* has been granted to more people including women than have similar doctorates of other sciences in Japan.

Finally, let us examine the numbers of medical students in the medical schools and colleges. Table VI has been compiled by postal inquiries to each school. The total is of 47 schools on Aug. 1, 1956 (21 national, 13 municipal or public, and 13 private). According to this survey there are 1,065 women students, or 8.4 per cent, of the total of 12,671. The national group has 4.4 per cent; municipal, 7.2 per cent; and private, 15.7 per cent of the total. The private schools have a larger percentage chiefly because of the existence of the three former women's medical colleges (the present Tokyo, and Toho and Kansai Medical Colleges), all of which are private. If they were excluded, the percentage would drop by almost half. To study this more closely, of 45 schools there were, in 1953, 6 with 1 to 4 women students, 6 with 5 to 9 women students, 10 with 10 to 14 women students, 10 with 15 to 19 women students, and 13 with more than 20 women students. If the total number of 1,065 women students of that year were evenly divided, each school would have over 23 students. As a matter of fact, over half the schools have fewer than 14 women students. This again was because of the existence of the three women's colleges, former and present, with their total of 455 women students (as was the case in 1956), or 42.7 per cent of the women students' total. Though the three colleges are so dominant, every medical school of a university has at least one woman student and the fact that there are none without a woman student has resulted from the new education system installed since the war. There are about the same number of students for each yearly group of classes in medical school.

The one thing worth considering is the question of which system, present or former, is best for mobilizing more students. Actually, before World War II when we had three colleges exclusively for

TABLE VI
Japanese Medical Students in 1956

Type of School	Men No. enrolled	Men %	Women No. enrolled	Women %	Total
National	5,948	95.6	273	4.4	6,221
Public	2,404	92.8	187	7.2	2,591
Private	3,254	84.3	605	15.7	3,859
Total	11,606	91.6	1,065	8.4	12,671

women, more women students were mobilized than are at present. Since the education system has undergone a change from the roots up, it is hard to make an impartial comparison. However, in the year 1938, the 17 medical schools of universities and 9 colleges had 12,894 students, including preclinical students in colleges, of whom 1,954 were women. This was an average of 390 students for each yearly class, or about 15 per cent of the total, a much higher percentage than exists at present.

From the figures presented, we can surmise that the number of women students increased yearly up to the end of the war in proportion to the increase of the total for all doctors. After the war, until about 1948, the same rate of progress was maintained. Between 1949 and 1952 there was a jump of about 60 per cent from 506 women students in 1946 to 809 in 1952. In 1953, a steadying trend set in, and, as the 1956 figures show, a slow but constant increase of about 9 per cent is expected for the future.

Bibliography

Fujikawa, Y.: History of Medicine in Japan, Tokyo, Nisshin Publishing Store, 1940, vol. 1.

Nagatoya, Y.: About women doctors in Japan: History of their education and present status, Jap. M.J., Sept. 3, 1955, no. 1636.

Statistically Surveyed Report on Medical Doctors and Dentists, compiled and published by the Research Department, Welfare Ministry of the Japanese Government, Toyko, 1956, vol. 1.

Yayoi Yoshioka's Autobiography, Tokyo, Rengo Fujinkai (Women's Association), 1940, vol. 1.

Child Therapy

The Karen Horney Clinic in New York City, established in 1955 to provide free and low cost psychoanalytic care for those who cannot afford private treatment, has recently added a department of child therapy to treat children from 6 years of age and older. More than 60 medical doctors contribute their skill, time, and professional service without charge. Both individual and group therapy is provided for children and adults, regardless of their race or creed. A modest, nonprofit fee, adjusted to income, is charged to those who are able to pay; free to others.

FDA Denies Sale of Hydrocortisone Lotions Without Prescription

The Food and Drug Administration has published an order denying proposals to permit sale without prescription of ointments and lotions containing hydrocortisone and hydrocortisone acetate. Such products are prescribed for relief of various skin disorders. The ruling, published in the Federal Register, summarizes the evidence for and against the proposal as well as the Food and Drug Commissioner's findings and order.

According to the Commissioner's statement, the available evidence fails to show that these drugs are safe for use without medical supervision. In particular, there is insufficient evidence to show the range in the amount of hydrocortisone that is absorbed through the skin and the clinical significance of such absorption.

Ten pharmaceutical firms had petitioned FDA to exempt the drugs from the prescription-dispensing requirement. A proposed order to this effect was published in the Federal Register on Jan. 20, 1956. It was challenged by members of the medical and pharmaceutical professions, and a public hearing was called to receive further evidence. Based on testimony from dermatologists, the FDA reversed its proposed decision. The present order, however, does not prejudice the right of petitioners to renew their proposal and present further scientific data.

Medical Highlights

TWO-WAY COMMUNICATION FOR MEDICAL CONVENTIONS

Two of the world's great medical confraternities —the physicians of the United States and the United Kingdom—were linked across the Atlantic via the new underseas cable on June 5, 1957. Thus, for the first time in history, two medical conventions on different continents were in direct, two-way communication.

Arranged by Smith, Kline & French Laboratories, Philadelphia pharmaceutical manufacturers, the hook-up joined the American Medical Association, then in annual session in New York, and the Harvey Tercentenary Congress, convened in London to commemorate the three hundredth anniversary of the death of William Harvey, the English physiologist who first described the circulation of the blood.

Fittingly, doctors both in New York's Carnegie Hall and London's venerable Great Hall of the Royal College of Surgeons discussed: "The Results of Cardiac Surgery."

HYPOTHERMIA FOR HEART REPAIR

The use of hypothermia, or "refrigerated sleep," to suspend the work of the heart for repairs may be safer in the future with the application of new research findings by U. S. Public Health Service scientists.

Drs. Thomas A. Lombardo, Leo R. Radigan, and Andrew G. Morrow found in animal experiments that the threat of heart muscle failure in such operations could be greatly reduced by injections of strophanthidin, a digitalis-like "heart tonic" from the seeds of the African *Strophanthus* shrub. A description of the technique appears in the January issue of *Circulation.*

The use of hypothermia permits many otherwise impossible heart operations because, by lowering body temperature 12 degrees below normal (in an ice bath), it reduces the need of most body tissues for blood-borne oxygen. This allows the surgeon a period of 8 to 10 minutes to clamp off blood flow through the heart's chambers and to work inside.

Heart muscle failure sometimes develops apparently because the heart muscle needs a more continuous oxygen supply than other body tissues. Even in the chill of hypothermia it soon weakens in the absence of blood and, when the surgeon restores flow through the heart, it may be flabby and fail to perform its pumping job effectively.

In their experiments with strophanthidin the researchers lowered the body temperatures of a number of dogs 15 to 20 degrees below normal in ice baths. They then clamped off the blood flow into the dogs' hearts and opened their right ventricles, as if to perform surgery inside. Half of these dogs received three injections each of strophanthidin at 5-minute intervals beginning 15 minutes before circulation was interrupted. The other half did not receive the drug and served as controls. Seventy per cent of the dogs unprotected by strophanthidin died, either during surgery or within 24 hours afterward, showing flabby dilated hearts and other evidences of heart muscle failure. Less than 18 per cent of the strophanthidin-treated dogs died within 24 hours, and in 3 of these the researchers found evidence that heart muscle failure may not have been responsible.

Strophanthidin was used rather than one of the more common digitalis heart stimulants because of its comparatively fast, short-term heart tonic action. "This rapidly acting digitalis preparation given before inflow occlusion prevented the evidences of myocardial (heart muscle) failure in most of the animals and thereby increased survival," the researchers explained. "The data indicate that short term digitalization enables the myocardium to withstand temporary anoxia (oxygen deficiency)."

To date, the method has been used in hypothermia operations on more than 20 patients at the National Heart Institute.

PREVENTION OF RHEUMATIC FEVER AND PROPHYLAXIS AGAINST BACTERIAL ENDOCARDITIS

The American Heart Association, in a revised statement on "Prevention of Rheumatic Fever and Bacterial Endocarditis Through Control of Streptococcal Infections" (December, 1956, issue of *Modern Concepts of Cardiovascular Disease*), recommends the following changes for the prevention of rheumatic fever: 1. Greater emphasis is placed on the value of throat cultures in diagnosing streptococcal infections, with a view to stimulating an increased use of cultures, particularly when clinical

manifestations alone are inconclusive. 2. The Committee on Prevention reaffirms its view that continuous prophylaxis should be maintained indefinately for known rheumatic subjects, but recognizes that some physicians may wish to make exceptions in certain of their adult patients, particularly those without heart disease who have had no rheumatic attacks for many years. 3. Monthly injections of 1,200,000 units of benzathine penicillin G intramuscularly is now listed first among prophylactic methods. The Committee also indicates that it is preferable, if oral penicillin is chosen as the method of prophylaxis, to prescribe 200,000 to 250,000 units twice daily, rather than once daily, providing an additional safeguard against the break-throughs reported with the smaller dosage.

The Committee also has revised the recommended dosages for prophylaxis against bacterial endocarditis in patients with rheumatic or congenital heart disease who are obliged to undergo such surgical procedures as dental extractions and tonsillectomies. Emphasizing that the dosage regimens used for long-term prophylaxis of streprococcal infections are inadequate for this purpose, the Committee recommends that high blood levels of penicillin be maintained for several days (rather than, as previously stated, on the day of operation alone) to prevent organisms from lodging in the heart valves during the period of transient bacteremia. In general, the following combined oral and parenteral route of administration is preferred: oral penicillin (200,000 to 250,000 units four times a day) for the two days before and the two days after surgery; the same dosage of oral penicillin on the day of surgery, plus 600,000 units of aqueous penicillin with 600,000 units of procaine penicillin shortly before operation. Alternative recommendations are included for situations in which injection is not feasible or penicillin is contraindicated.

RELATIONSHIP OF PHOSPORAMIDES AND CANCER

Renewal of the Atomic Energy Commission contribution of $20,430 toward support of the project "Investigation of Distribution, Localization and Excretion of Tagged Triethylene Thiophosphoramide Following Injection by Various Routes" has been approved for another year. The project is under the direction of Dr. Jeanne C. Bateman and is being carried out at the Garfield Memorial Hospital in Washington, D.C.

The Lederle Laboratories Division of the American Cyanamid Company has renewed the grant for $12,000 to the Garfield Memorial Hospital for the "Study of Carcinolytic Action of Certain Phosphoramide Drugs on Human Cancer." Dr. Jeanne C. Bateman is the chief investigator.

CEREBRAL DANGER IN LEUKEMIA THERAPY

Cerebral complications including severe involvement of the meninges and brain parenchyma, with perivascular infiltration, were found in 7 of 27 children undergoing antileukemia therapy at the M. D. Anderson Hospital, Texas. The symptoms, suggestive of a brain tumor, were found to be due to leukemia infiltration, the signs of which do not appear until 5 to 12 months after chemotherapy is begun. Dr. Margaret P. Sullivan of the University of Texas stated that the syndrome did not result from the agents themselves but rather from their failure to cross the blood-brain barrier in therapeutic amounts. She finds roentgen-ray therapy of the entire skull the most effective treatment for intracranial leukemia, since no existing antileukemia agents are able to cross the blood-brain barrier.

GLYCEROL PROTECTION IN SPERM STORAGE

A laboratory accident at the division of experimental biology of the National Institute for Medical Research in London, in which glycerol (rather than glucose) was used to protect fowl spermatozoa in storage at below freezing temperatures, may make "suspended animation" a scientific reality.

Since this development, deep-frozen, glycerol-treated human sperm have been used to impregnate three women in the United States, all of whom bore normal children. Cows also have been fertilized by sperm stored at –79 C. for four years.

At a symposium sponsored by the Royal Society of London, Dr. A. S. Parkes, who with C. Polge and Dr. Audrey Smith made the original discovery, stated that ovaries from a rat, glycerol-treated and stored for months at below freezing temperatures, were placed in another ovariectomized rat, which has since bred.

Without using glycerol, Dr. Smith has frozen golden hamsters to the point at which heart and respiration stop. After an hour they can be revived by diathermy and artificial respiration; however, since they cannot be revived after several hours of sub-zero storage, Dr. Smith is attempting to apply glycerol protection to the whole animal. If glycerol were able to reach all cells, animals could be kept in suspended animation indefinitely.

World Health Organization

U. S. GOVERNMENT CONTRIBUTES ONE AND A HALF MILLION DOLLARS FOR MALARIA ERADICATION

The solution of the international public health problem of highest priority in the Americas was advanced one step forward by a special contribution of 1.5 million dollars, made by the U. S. government to increase the Special Fund of the Pan American Sanitary Organization for malaria eradication.

"Malaria is still a leading cause of death in many parts of the world, including some areas in the Americas," stated Dr. Fred L. Soper, Director of the Pan-American Sanitary Bureau, Regional Office of WHO, in a ceremony in which the representative of President Eisenhower, Dr. Milton S. Eisenhower, presented the check from his government. "Its continued existence anywhere in this hemisphere threatens reinfection in all areas where malaria has been eradicated. Science has given us a powerful new weapon in the residual insecticides, such as DDT, which make the eradication of malaria possible and practicable throughout the Americas. But there is also a deadline we must meet," he continued, "since mosquitoes eventually develop resistance to these insecticides. If we move too slowly, the job becomes vastly more difficult and costly. That is why we have given first priority to the malaria eradication program. The Pan American Sanitary Organization is urging governments to expand and accelerate their national eradication programs."

Each year some 250 million persons throughout the world are afflicted with this disease, some 2 million dying of it annually. Here in the Americas, there are still extensive malaria areas and there are only a few countries where it is nonexistent or has been eradicated. Malaria has been eradicated from the United States, for instance, only in the past three years.

MEDICATED SALT FOR MALARIA

Director-General M. G. Candau in his Annual Report to the Tenth World Health Assembly, which opened on May 7 in Geneva, states that mosquito resistance to insecticides, which occurred in certain parts of Greece, was responsible for shifting WHO's malaria policy from mere control to eradication. "It is clear," says Dr. Candau, "that, were conditions similar to those in Greece to appear elsewhere, the chances of success of eradication campaigns would be seriously jeopardized and it might be necessary to change the methods of interrupting transmission. "One way of solving the problem might be the distribution of salt for human consumption containing anti-malarial drugs, since preliminary results of a study promoted by WHO of the effect of such medicated salt on volunteers inoculated with malaria seem encouraging."

FELLOWSHIP AWARDS CONTINUE TO RISE

The Pan American Sanitary Bureau has announced that it made a total of 430 awards in the Americas during the 1956 reporting year, a 6 per cent increase over 1955. Fellows arriving from other regions of WHO for study in the Americas increased by about 20 per cent over 1955.

Once again there was broad participation by the countries and territories of this hemisphere. Awards were made to nationals of every country, which in turn received fellows from other countries for training.

There was increased emphasis during the year on fellowship grants in connection with malaria, and for smallpox and the diarrheal diseases. Fields of training also included, among others, public health administration and education, sanitation, health statistics, nursing, laboratory techniques, and hospital administration.

American Medical Women's Association

Retiring President's Message

In the preaviation days of my youth, a friend was fond of quoting this saying: "It is better to aim for a star and hit the fence than to aim for the fence and hit the ground."

The Association aimed for a star this year and, I feel, cleared the fence, thanks to the wholehearted support given your Executive Committee by the membership.

I wish to thank all the officers and the committee chairmen and members, as well as all the members of the Association who have worked and helped in the past 12 months. My thanks go not only to those whose names appear in the minutes or in the JOURNAL but to all of you who have put in time and energy so that projects and plans could be finished successfully. You will find all the details in the various reports given at the Annual Meeting, and I am certain they will encourage you, individually and in groups, to augment your efforts for the common good.

Your newly elected officers are taking office this month. That you will give them the same wholehearted co-operation that you have given us is certain.

Let me send all of you, officers and members alike, my best wishes for a very happy and successful year. Above all, let me express my deepest gratitude for having been allowed to serve you this year.

Camille Merrill

President's Message

The object of this organization is to bring medical women into association with each other for their mutual advantage; to encourage social and co-operative relations within and without the profession; to further such constructive movements as relief work and public health; to aid women medical students; and to assist women physicians in postgraduate work.

To be the leader of an organization with such a comprehensive and lofty aim is a responsibility, not undertaken lightly. After such fine leadership as I have witnessed in my six years of attending national meetings, it is with profound humility and dedicated earnestness that I attempt to assume the office with which I have been honored.

As I reflect upon the statement of the objectives of AMWA, as your President I must call upon each member, individually, and each branch, with its collective strength, to pause for similar reflection. Let us each measure our past adherence to this goal and set out to fulfill it more completely during the coming year.

If you are a member at large, you can lend a bit of your time to the first objective. Extend the invitation to membership to other women in your area and help bring about a new branch. Our Executive Secretary, Mrs. Majally, the Chairman of the Organization and Membership Committee, Dr. Jane Schaeffer, the Regional Director of your area, or myself, will give you all the assistance you wish. Do not hesitate to communicate with one or all of us. Are you a member of a branch or an officer? You, too, can extend fellowship and invite membership.

Let us endeavor to keep in mind the rest of the objectives in planning branch programs for the coming year. If every branch took one civic problem to work on each year and made their efforts felt by the scope of their accomplishments, we would have no membership problem. Any woman in practice would be embarrassed not to have membership. Is AMWA as well known in your town because of its service as it is in Greece through the work of the American Women's Hospital? Do you have a preceptor program? What are you doing to help the medical student, intern, resident (American or foreign born), and the oft bewildered young woman doctor starting out in practice?

We are not organized to compete with men or strive for special rights. Great and noble souls have done most of this pioneering for us. But we are women as well as physicians. We have special talents as well as special problems. Among our membership we have experience with the problems of the working mother, of the career woman without the responsibilities of marriage, and of the medical and social aspects of retirement and career extension into older age. We have insight into marital problems; physical, emotional, and social problems; and the many complications of medical school, internship, and the early years of practice. Be you junior, associate, or active member, your voice should be heard by AMWA, your needs expressed, your experience shared, and your wisdom and talents pooled to accomplish the objectives of AMWA as completely as possible.

The joy of living is largely the joy of giving. To be sure, AMWA needs you much more than you need AMWA; yet, if you are active in AMWA in giving your time and talents to its objectives, intangible rewards will be yours and women you may never meet will be grateful to you.

Your officers hope the program theme "The Emotional Health of the Family" will prove one around which members and branches can participate in fulfilling the objectives of AMWA in their programs, in their offices, and in their communities.

Elizabeth S. Kahler

Association News

MEDICAL EDUCATION

Medical School—a Catalyst for Community Leadership

The Woman's Medical College of Pennsylvania has initiated a program of leadership development. At the hundred and seventh Founder's Day Celebration and third annual forum for mutual discussion of medical data by national leaders in medicine and medical education and by leaders of business, industry, and public service, Dr. Burgess L. Gordon, President of the College, said: "In an era of community-wide preoccupation with health and the conquest of disease, it is shocking to note that the medical profession as a whole is not playing a responsible role in community leadership. It seems to us at Woman's Medical College that we have a responsibility in today's world to incorporate into our preparation of candidates for the medical profession an appreciation of this responsibility to share in the leadership of the community in a demonstration of what a college can do in taking leadership in health education."

Five nationally prominent specialists spoke on subjects ranging from nutrition to heart disease before an audience of about 700.

John B. Prizer, Chairman of the Board of Corporators of the College, said in summation that the medical school is "the logical catalyst for achieving the goal of unity between medical men and women and the public they serve."

Standards Have Been Raised

The American College of Allergists has raised its standards for the classification of Fellow. No physician, however well trained, can become a Fellow in the College unless he has either been "certified" by the various medical boards or has passed a written and oral examination prepared by the Board of Examiners of the American College of Allergists. Candidates will be required to take two written examinations of three hours each, covering every aspect of the vast and complex field of allergy. A 30 minute oral examination will be conducted by two examiners.

Postdoctoral Fellowships in Research

Three postdoctoral fellowships in research and clinical allergy have been established for 1957 at Johns Hopkins, University of Pennsylvania, and Washington University (St. Louis) by the American Foundation for Allergic Disease, a voluntary agency established in 1953, which co-operates with the National Institute of Allergy and Infectious Disease of the U.S. National Institutes of Health. Research, medical and public education, and improvement of patient care facilities in the field of allergic disease are included in their program.

How the AMWA Serves Medical Women

The following letter to the executive secretary expresses the gratitude of an associate member for the services rendered by the AMWA.

"I take this opportunity to reiterate my gratitude for all the help you gave me last year. I may not be able to express how much I appreciate your kindness and your desire to help me but I am sure that you understand how grateful I have been.

"The pediatrics residency program [University State Hospitals, Iowa] is excellent and I have enjoyed my training. A resident in this department is placed in a situation similar to that of a pediatrician in practice outside. He has inpatients (in the ward) and clinic patients and sees patients in consultation or refers them to the needed specialty. This hospital has a unique transportation system that brings indigent patients here from all over the state for admission or to be seen, and since this is a state institution we have many patients and a variety of clinical material. Our senior staff members are very good and very willing to teach us.

"Residents are given special assignments for a period of two months each time, in addition to their regular patient load. There are three such assignments: (1) consultations—seeing patients referred to our service by all the other services; (2) nursery—taking care of newborn babies and attending cesarean sections and exchange transfusions; and (3) admissions—receiving all long-

distance calls from the referring physicians, scheduling appointment, and assigning patients.

"Patients have three classifications: (1) indigent or state, (2) clinical pay (they pay part of the expenses), and (3) private patients. The children we see are mostly of the first two classifications, but we also examine private patients.

There are six residents in pediatrics. Besides the six of us, we have a chief resident, a fellow, and a part-time resident. Three of us are in our first year residency. As is to be expected, we all have to work hard because of the great responsibilities we shoulder. The second year residents work equally hard, although they, of course, do not have the problems of one who is just beginning. I have encountered problems with other services, which is perhaps inevitable in a big institution, but my senior staff has stood behind me each time.

"In spite of the fact that I miss my folks I would like to take a second year pediatrics residency here because of the wonderful opportunities.

"I have always considered myself lucky for having had the opportunity of meeting you in Salt Lake City. I wish you more luck and success!"

LOURDES L. ALEJANDRINO, M.D.

Dr. Alejandrino is a resident in pediatrics at University State Hospitals, State University of Iowa. Dr. Alejandrino received her M.D. degree from the College of Medicine of the University of Santo Tomas, Manila, Philippines, in 1953. She observed in the Department of Medicine at the university for six months and became an extern in the Department of Pediatrics, North General Hospital, Manila, in 1954. She came to the United States for an internship at St. Mark's Hospital, Salt Lake City, Utah, in December of 1954. Her visa was to expire in May, 1956, before completion of her postgraduate training.

Dr. Alejandrino attended the branch organization meeting in Salt Lake City in March, 1956, when the service program of the American Medical Women's Association was outlined. She wished to remain in the United States to undertake training in pediatrics. Her story was presented to branch presidents who sent information about available residencies to her. (L.T.M.)

LEGISLATION

Time to Act

Are you interested in the plan that would permit a self-employed person to put a small part of his income into a retirement fund, deferring payment of taxes on the amount until it is received in the form of retirement? If so, secure pamphlets on the Jenkins-Keogh Bills H.R. 9 and 10 from the American Thrift Assembly, 1025 Connecticut Ave., N.W., Washington, D.C., and contact the members of the House Ways and Means Committee urging favorable action immediately.

Blackwell Awards of the New York Infirmary

The annual Ceremony of Award of the Elizabeth Blackwell Citations to women physicians for distinguished contributions to medicine took place on Jan. 27, 1957 at the New York Infirmary, Stuyvesant Park East and Fifteenth Street. These awards, established in 1949 by Mrs. Frank Vanderlip, President of the New York Infirmary, honor women doctors.

Mrs. Frank Altschul, Chairman of the Elizabeth Blackwell Citations Committee, gave a luncheon at the Gramercy Park Hotel for the candidates, the trustees, the directors of departments of the Infirmary, a number of guests, and for Dr. George Armstrong, Director of the New York University-Bellevue Medical Center. The ceremony, at 3:30 p.m., followed.

The recipients of the 1957 Citations were: Dr. Virginia Kneeland Frantz of New York City, who was cited for her outstanding contribution in research and the teaching of surgical pathology; Dr. Margaret Irving Handy of Wilmington, Del., who was cited for her outstanding work in the practice and teaching of pediatrics; and Dr. Madge Thurlow Macklin of Columbus, Ohio, who was cited for her outstanding contribution in the teaching of genetics and research in cancer.

Mrs. Altschul presided at the ceremony and presented the candidates to Mrs. Vanderlip, who conferred the Awards. Dr. George Armstrong delivered the Ceremonial Address. There were about 250 present, and tea was served at the conclusion of the ceremony.

Left to right: Dr. Virginia K. Frantz, Dr. Margaret I. Handy, Dr. Madge T. Macklin, Mrs. Frank A. Vanderlip, Dr. George Armstrong, and Mrs. Frank Altschul. (Photo by Warman, New York Herald Tribune)

CITATIONS

"The New York Infirmary hereby makes this citation of Dr. Virginia Kneeland Frantz for her contributions to fundamental research and teaching in surgical pathology.

"Four years after admission to the College of Physicians and Surgeons of Columbia University, she became the first woman surgical intern in the history of the Presbyterian Hospital. She then turned to the field of surgical pathology, and, having married a fellow medical student, to the raising of a family. Since then, her work has been continuous and outstanding.

"As a teacher of medical students, Dr. Frantz is one of the really gifted, and now holds a full professorship in surgery at Columbia University, College of Physicians and Surgeons. As a research scientist she is a recognized authority on the thyroid and pancreas. Perhaps her most notable contribution was a new concept, directly affecting operative surgery. In collaboration with Dr. Hans Clarke, Professor of Chemistry, this concept resulted in development of oxidized cellulose, the first of the absorbable hemostatic agents, now widely used for control of operative internal bleeding.

"Dr. Frantz has had the recognition of her peers, as evidenced by her election to the presidency of the New York Pathological Society, a position which she held for three years. Her eminence in her chosen field has not prevented the enjoyment of a full and rounded life as mother, grandmother, dairy farmer, and hostess extraordinary.

"The New York Infirmary is proud to confer an Elizabeth Blackwell Award on Dr. Virginia Kneeland Frantz."

"The New York Infirmary hereby makes this citation of Dr. Margaret I. Handy in recognition of her outstanding work in the practice of pediatrics.

"Following her medical education and specialized pediatric training at Johns Hopkins University Medical School, Dr. Handy started her practice in Wilmington—the first pediatrician in Delaware. For almost 40 years she has been more responsible than any other individual for setting and maintaining high standards of pediatric practice in her state.

"An indefatigable and patient teacher of younger physicians and nurses, she has never ceased to be a student herself, keeping abreast of continuing advances, and always ready to accept the new if it is an improvement over the old.

"A practicing physician, adored by her patients and their families, she has not lost sight of the community. Chief of the Pediatric Service of the Delaware Hospital until 1946, she organized and developed its premature nursery and continues to care for its ward patients despite her retirement from the active staff. She has served her state as member, for 18 years, of its Board of Health. As Delaware Hospital until 1946, she organized and emy of Pediatrics, she has guided national policies in her specialty.

"She holds an honorary degree from Goucher College, and in 1953 was named "Woman of the Year" by the state of Delaware for outstanding service to the community.

"The New York Infirmary is proud to add an Elizabeth Blackwell Award to the honors Dr. Margaret Handy has already received."

"The New York Infirmary hereby makes this citation of Dr. Madge Thurlow Macklin in recognition of her achievements in the field of human genetics and inheritance.

"Dr. Macklin, a Philadelphian, received her formal education in Baltimore. Much of her professional life has been spent in Canada. She graduated, first in her class, from Goucher College, 1914, and received her medical degree from the Johns Hopkins University Medical School, 1919. These educational opportunities were made possible largely by her success in winning fellowships. During the following years, while beginning her activities in teaching and research, and when established, later on, the help of an understanding husband enabled her to carry on her work while raising a family. Her medical career was launched in 1921, at the University of Western Ontario, in the Department of Histology and Embryology, and, in 1948, she became, and continues to be, Research Associate in Medicine and Lecturer in Medical Genetics at Ohio State University Medical School.

"Dr. Macklin's active interest in the diverse and well nigh innumerable problems of medical science in which genetics plays a part is reflected in the varied subjects of her publications. Her major concern, however, in recent years has centered on problems of malignant disease in humans. To these inquiries she brings a rich experience gained in her genetic studies.

"Her contributions to the better understanding of medical genetics have brought Dr. Macklin many honors, and the New York Infirmary is indeed proud that her most recent one is an Elizabeth Blackwell Award."

News of Women in Medicine

ULKA SEMA ARAN is reported by the Turkish Information Office to be the first woman to graduate from the Military School of Medicine in Ankara. There are eight other women medical students "all doing very well indeed," according to the Dean of the Army Medical School.

DR. EMILY DUNNING BARRINGER was the subject of a special feature report by Meyer Berger of the *New York Times* on Feb. 18, 1957. As part of the celebration of the 150th anniversary of the Medical Society of the State of New York, the last horse-drawn ambulance in the city was driven through Manhattan. The original plan for the event was to have Dr. Barringer ride the ambulance. In June, 1903, Dr. Barringer, a Cornell graduate, was the first woman intern to ride a hospital ambulance. She was 27 years of age at the time and had "won the job many times but interns all over the city had petitioned against her appointment." Dr. Barringer, now 80, wished she could have come in from Connecticut "to ride the ambulance when it rolled again" but was prevented by a death in the family.

A paper on the palliation of cancer in human patients by maintenance therapy with N N^{1} N^{11} triethylene thiophosphoramide was presented by DR. JEANNE C. BATEMAN in New York City on March 29 at the Conference on Comparative Clinical and Biological Effects of Alkylating Agents. The meeting was sponsored by the New York Academy of Science and the Cancer Chemotherapy National Service Center.

DR. PHYLLIS A. BOTT, Professor of Physiological Chemistry at Woman's Medical College has just received a renewal of a research grant from the Life Insurance Medical Research Fund to continue her work in kidney physiology. The grant, $29,700, is for a period of three years. Dr. Bott's studies on the kidney using microtechniques have added importantly to the knowledge of the functions of this important organ.

DR. THELMA BROCK of Buffalo, N.Y., has been elected to fellowship in the American College of Allergists.

DR. NAOMI L. DALTON of Bloomington, Ill., has gone to Velore, South India, where she will be anesthesiologist at Christian Medical College and Hospital, to fill a missionary assignment under the auspices of the Methodist Church.

DR. HELEN DICKIE is serving on a research team at the University of Wisconsin Cardiovascular Research Center in Madison, whose goal is to learn more about the origin and effects of silo-fillers' disease.

DR. LUCY L. EDENBOROUGH has been awarded a $2,400 fellowship in the Department of Pathology by the American Cancer Society. Dr. Edenborough is a resident in oncology and pathology at Woman's Medical College of Pennsylvania.

FLOY HELWIG, student at Woman's Medical College of Pennsylvania, served on the local arrangements committee for the Student American Medical Association's annual meeting in Philadelphia, May 3-5, 1957.

DR. MARY A. HIPPLE has been elected to the presidency of the staff of the Woman's Hospital of Philadelphia.

DR. EVELYN MERRICK, rheumatologist at the Orange Medical Center, Orange, N.J., co-operated with Dr. Joseph Eidelsberg (Associate Professor of Clinical Medicine at New York University's Post-Graduate Medical School and Chief of the Endocrine Clinic at University Hospital, New York) and Dr. Abraham Kolodin (Senior Attending in Medicine at Mountainside Hospital, Montclair, N.J.) in the production of a film on hormone therapy and the endocrines, which was produced by the Clinical Research Division and Biochemical Research Department of the Schering Corporation.

DR. LUELLA NADELHOFFER, DR. AUGUSTA WEBSTER, and DR. ABBIE RUTH LUKENS of Chicago, DR. GOLDIE B. CORNELIUSON of Lansing, Mich., and DR. MARY L. NEWMAN of Jacksonville, Ill., served as leaders or co-leaders of round-table discussions during the First Illinois Congress on Maternal Care, held in Springfield in February. The theme for the meeting was "Illinois Reviews Its Maternity Care."

KATHERINE BROWNELL OETTINGER, Dean of the

School of Social Work of Boston University, has succeeded DR. MARTHA ELIOT as Chief of the Children's Bureau, Department of Health, Education, and Welfare. Dean Oettinger has been a division chief in the Bureau of Mental Health, Pennsylvania Department of Welfare; has served as a psychiatric social worker at a children's treatment center in Scranton, Pa.; and has been employed in child guidance and family welfare work in New York City. She has served on the Board of Directors of the Massachusetts Association for Mental Health and on the advisory committees of the American Child Guidance Foundation.

DR. YAEKO OHTA, a surgeon at Women's Medical College of Tokyo, Japan, has come to New York to study plastic surgery as assistant to Dr. Morton I. Berson, Chief of the Plastic Surgery Department, Wickersham Hospital. Dr. Berson after delivering a lecture before the Japanese Medical Association in February, 1957, suggested that Japanese surgeons be sent here for special training so that treatment could be provided for the 4,000 Japanese needing such care.

DR. ADA CHREE REID of New York has been reelected to the Board of Directors of the United States Committee, Inc., of the World Medical Association. The United States Committee is one of several national committees organized to support the activities and achieve the aims of the World Medical Association, the international organization of the doctors of the world.

Activities of the Committee include: mutual exchange of visits of foreign doctors; exchange programs of magazines, textbooks, and scientific and medical publications; resettlement of refugee doctors; establishment of a central repository for medical credentials; promotion of an emblem to identify and protect civilian doctors, their ancillaries, and supplies in case of war or disaster; and providing of opportunities for the development of professional and personal friendships among doctors of the world.

A second recent honor to come to Dr. Reid was appointment by Mayor Robert F. Wagner to the Advisory Commission on the Aged of the Department of Welfare for New York City. Dr. Reid will work in the special Housing Category.

DR. JANET RIOCH of the William Alanson White Institute of Psychiatry in New York and DR. J. LOIS DESPERT, Cornell University Medical School, were two of the discussants at the annual conference of the Child Study Association, held in New York, March 25, 1957. Nearly 1,000 psychiatrists psychologists, teachers, parents, and social workers from the United States and Canada attended. The theme of the discussion was "Man's Changing Role in the Family of Today."

Dr. Rioch stressed the need for more research on social and emotional problems within the family. Dr. Despert discussed "The Fatherless Family" and said that the most important single factor common to all cases of a fatherless family was the emotional climate of the family and the emotional maturity of the mother at the time of separation. Other points brought out were: "a need to recognize that bringing up children is a partnership of equals," "there is no such thing as an ideal father," and "many young people are working out happy marriages tailored to fit their own and their children's needs."

DR. CLAIRE F. RYDER of Washington, D.C., returned to Boston, where she previously was associated with the Harvard School of Public Health, on March 20 to speak before the College Club on a "New Look at the Old." She discussed what community agencies are doing or planning to do for our senior citizens.

DR. MARY SHERMAN, an orthopedic surgeon of New Orleans, was the featured speaker on April 28 at the meeting of the Pediatrics, Orthopedics, and Radiology joint section of the 103rd Annual Session of the Medical Association of Georgia. Her topic was "Some Common Skeletal Diseases in Children." The clinical, radiologic, and pathological aspects of several disorders of childhood that are frequently missed or confused with more serious diseases were discussed. Dr. Sherman was also a panelist at the same meeting to discuss "Modern Everyday Concepts of Scurvy and Rickets."

FRANCES LOIS WILLOUGHBY, MC, USN, Staff Psychiatrist, was officially advanced to the rank of Captain on Feb. 5, when she was presented with a pair of silver eagles, insignia of her new rank. Dr Willoughby entered the U. S. Naval Reserve in February, 1944, and the regular Navy as LCDR in October, 1948, becoming the first woman physician in the U. S. Navy. A Navy career was not the intention of Dr. Willoughby; however, she liked the service and has not regretted her decision. Captain Willoughby is stationed at the U. S. Naval Hospital in Philadelphia.

Opportunities for Women in Medicine

AWARDS

General Practice: A series of prizes for physicians of any country has been announced by B. D. Thornley, Managing Director of Benger Laboratories, British pharmaceutical firm. The prizes total 500 pounds in value and will be known as the "Benger Prizes for Original Observations in General Practice." Entries may be concerned with the causation, treatment, or prevention of any disease. All entries will be published, and the book will be available to physicians everywhere. Entries will be judged by the awards committee of the British College of General Practitioners. Manuscripts or correspondence should be directed to Benger Laboratories, Ltd., Holmes Chapel, Cheshire, England.

Medical Sciences: Nominations for the Borden Award in Medical Sciences for 1957 are now open. This is the tenth anniversary of the establishment of the award, which consists of $1,000 in cash and a gold medal to be granted in recognition of outstanding clinical or laboratory research by a member of the faculty of a medical school that is a member of the Association of American Medical Colleges. For further details write D. F. Smiley, M.D., 2530 Ridge Ave., Evanston, Ill. The closing date is Aug. 1, 1957.

Plastic Surgery: Prizes of $1,000 and $750 will be awarded for the two best essays on original research in plastic surgery by plastic surgeons who have been in practice for less than five years. Two silver plaques will be presented: to a plastic surgeon who has been in practice for more than five years and to a researcher outside the field of plastic surgery. Information may be obtained from Dr. Clarence R. Straatsma, President, Foundation of the American Society of Plastic and Reconstructive Surgery, 5 E. 83rd St., New York 3.

COURSES

Endocrinology: The Ninth Postgraduate Assembly in Endocrinology and Metabolism will be held at the Medical College of Georgia in Augusta, Oct. 21-25, 1957. The Assembly will be co-sponsored by the Endocrine Society, the Medical College of Georgia, and the Medical College of Georgia Foundation, Inc. Registration will be limited to 100. Twenty-two eminent clinicians and investigators from various parts of the country will present courses to cover the main aspects of diagnosis and therapy in the field of endocrinology and metabolism for the physician in general practice and for those in other specialties who wish to have a general knowledge of this rapidly growing field. The course has been approved by the American Academy of General Practice for 35 credit hours in Category 1. For complete information, write to Dr. Robert B. Greenblatt, Department of Endocrinology, Medical College of Georgia, Augusta.

Mental Retardation: A workshop for professional personnel on "The Vocational Rehabilitation of the Mentally Retarded Adolescent and Adult" will be conducted at Teacher's College, Columbia University, July 29 to Aug. 16, 1957. The university and a state organization (the Association for the Help of Retarded Children, Inc.) are co-operating to provide a three week intensive experience organized around the philosophy, problems, goals, and techniques in facilitating the work adjustment of mentally retarded adolescents and adults. A manual to help all professional workers concerned with rehabilitation of the mentally retarded will be produced co-operatively by the co-ordinators and the workshop participants. Students who meet the entrance requirements of Teachers College will receive three graduate credits for the workshop. Students may also enroll as noncredit students. For further information, apply to Dr. Abraham Jacobs, Box 35, Teachers College, Columbia University, New York 27.

RESIDENCY PROGRAM

Preventive Medicine: A residency training program in preventive medicine has been announced by the Army Surgeon General's Office in Washington, D.C. This residency provides both civilian and military training. Eleven months of the first year program will be devoted to military preventive medicine at Walter Reed Army Institute of Research in Washington or to an equivalent graduate course in preventive medicine or public health at

a civilian university. The second year will be spent in an approved civilian residency training program in a city, county, district, or state health department. The third year will consist of formal military residency training at a large Army post, with a short time spent at a nearby Army headquarters under the supervision of the preventive medicine officers. This training will be followed by three years of practice in the specialty to establish eligibility for Board examinations. Approval of this program has been requested of the American Medical Association's Council on Medical Education and Hospitals. Regular Army Medical Corps officers or qualified civilian physicians may apply to the Surgeon General, Department of the Army, Washington 25, D.C., attention of Personnel Division.

SCHOLARSHIPS AND FELLOWSHIPS

American Heart Association: Three lifetime career investigatorships, with $25,000 a year set aside to cover the stipend and help support the laboratory, have been announced by the American Heart Association. In addition, 80 established investigatorships, awarded for five year periods (subject to annual review) to highly qualified scientists conducting independent programs of research, have been announced. These carry stipends of $6,000 to $9,000 per year. Seventy-two of the awards are research fellowships given for one or two year periods, and they provide stipends from $3,500 to $6,000 per year to help young scientists prepare for research careers under experienced guidance. Further information may be obtained from American Heart Association, 44 E. 23rd St., New York 10.

New York University-Bellevue Medical Center: A fellowship at $7,000 a year for dermatologists who have completed their three year full-time training in dermatology and who wish to start or continue in a research or teaching career in dermatology (immunology, mycology, oncology, physiology, and radiation including radioactive isotopes) and a fellowship at $5,000 annually for graduate students or residents who have completed their basic science year at a recognized institution and who plan to do research or to assist in teaching in special fields have been announced. Application should be made to the Director, Service of Dermatology, New York Skin and Cancer Unit, 330 Second Ave., New York 3.

Northwestern University: A full tuition, four year scholarship to be awarded to an incoming freshman medical student has been established at Northwestern University. The scholarship program was made possible by Dr. and Mrs. John William Howser, Oak Hill, Ill., in honor of Dr. James K. Stack, Associate Professor of Orthopedic Surgery. A new student will be selected at the end of each four year period by the school's scholarship committee.

Public Health: Scholarships for the academic year 1957-1958 have been announced by the School of Public Health at Harvard. These scholarships are available to physicians, industrial physicians, public health nurses, dentists, and veterinarians with a college degree and satisfactory field experience who wish to obtain postgraduate education in the field of public health. Scholarship applicants must be eligible for admission to the School as a candidate for one of the following degrees: master of public health, doctor of public health, master of science in hygiene, doctor of science in hygiene, or master of industrial health.

INTERNATIONAL HOSPITALITY

With the news of the arrival of Hungarian refugees in Vienna, Dr. Esther Pohl Lovejoy, as Chairman of the Executive Committee of the American Women's Hospitals, immediately took a telephone poll of her committee and wired funds to the Austrian Medical Women's Association. This has been reported in detail elsewhere in the JOURNAL (February, 1957, p. 55).

In mid-February, Dr. Antoine of Vienna notified Dr. Lovejoy that two Hungarian women doctors were emigrating to America. One has since married a fellow refugee and moved away. On Feb. 22 Dr. Lovejoy and Dr. Tenbrinck went to Camp Kilmer to visit DR. MARGARET ZOLLER.

In answer to a request for a brief résumé, Dr. Zoller supplied the following sketch of herself: "I am a Hungarian refugee physician, having studied at the University of Budapest from 1946 to 1952. After graduation I worked for one year in a large hospital and three and a half years thereafter in a postgraduate clinic, always in internal medicine. In May, 1956, I took my specialty board examination and worked then as assistant to the professor. In 1953 the medical weekly magazine published my paper 'Sprue and the Resulting Osteomalacia.'

"In Vienna I received great aid from the Austrian Medical Women's Association through Dr. Hauenschild. When I said I was going to New York, I was given the address of Dr. Esther Pohl Lovejoy, to whom I wrote on arriving in Camp Kilmer. Immediately I received an answer and in two days a visit from Drs. Lovejoy and Tenbrinck. I was very pleased and felt myself no longer alone. Now I am living as Dr. Lovejoy's guest for several weeks until my English has improved and I can work in a hospital.

"What this has meant to me and what I have felt can only be understood by one who knows what it is to be a woman alone in a foreign country, with a poor knowledge of the language, knowing no one, and having no home."

CORRECTION

In "These Were the First" of March, 1957, page 89, the statement appeared that Edith Petrie Brown was head of Ludhiana Christian Medical College in India. The College has informed us that Dame Edith Brown of England was the founder and principal of Ludhiana Christian Medical College.

THESE WERE THE FIRST

DR. LAURETTA KRESS graduated in 1897 from the University of Michigan School of Medicine. She was a native of Flint, Michigan, but for many years lived in Orlando, Florida, with her husband Dr. Daniel Kress, who survives her, as does her daughter, Dr. Ora Kress-Mason, of Murray, Kentucky. For 32 years, Dr. Kress and her husband conducted the Washington Sanitarium in Takoma Park, Washington. They traveled in England and Australia giving lectures, and were active in developing the Seventh Day Adventist health and medical work. Dr. Lauretta Kress is thought to have held the country's record for numbers of babies delivered, including her own.

DR. EDITH MCCANN, graduate of Rush Medical College in 1914, was the first woman to have a membership record of 35 years in the Milwaukee Academy of Medicine.

DR. ANNA PANAYOTATOU, one of four women to graduate in 1905 from the University of Athens, Greece, was appointed Assistant Professor of the Faculty of Medicine at that institution. She practiced in Alexandria, Egypt, as municipal doctor and was the first woman after competitive examination to be a member of the personnel of the quarantine service for Egypt in 1936, an office which she held for 30 years. Her sister, Angelique, graduated in the same class from the University of Athens.

DR. HILLA SHERIFF, graduate of the Medical College of South Carolina, Charleston, in 1926, was the first woman to be President of the South Carolina Public Health Association, and has carried on public health work in the rural areas of North and South Carolina. In 1931, she became head of the American Women's Hospitals' rural service conducted by means of a healthmobile in Spartanburg County, South Carolina, and in 1932 she participated in opening the Maternity Shelter in Greenville County, of which she was made Director. She was head of the AWH service for six years, and at the end of that time she was given a fellowship to the Harvard School of Public Health.

—From the ELIZABETH BASS Collection
Rudolph Matas Medical Library, Tulane University.

SPECIAL BOOK REVIEW

A Thanks Offering

"In Greek Mythology, Asclepius, the God of Medicine, had several sons and daughters who followed in his footsteps. . . ."

Thus begins the book that we have been waiting for—"Women Doctors of the World" (The Macmillan Company, New York, 1957). Dr. Esther Pohl Lovejoy continues:

"Medicine undoubtedly began at home as a service rendered by women to their families and to the sick of the communities in which they lived."

Age after age this service is traced through the pictorial findings of archaeologists, the Bible, and other records of the Greco-Roman period to the Middle Ages, when women served on the faculty of the first secular medical school of the first university in Europe. As the medical profession developed, they were excluded from medical schools and limited to the practice of obstetrics, in which some of them achieved distinction, especially in France. There were, however, outstanding women who surmounted difficulties and received degrees from famous medical schools long before medical education became a phase of the woman movement in the English-speaking worlds.

"Frau Dorothea Leporin-Erxleben, by the favor of Frederick the Great, was admitted to the University of Halle, from which she was graduated by the Medical Faculty in 1754—the first woman to receive a doctor of medicine degree in Germany and perhaps in the modern world." (p. 189)

"By the simple expedient of wearing short hair and trousers and holding her tongue, a woman by the name of James Barry had secured a diploma from the University of Edinburgh Medical Faculty in 1812, and was steadily rising in the British medical service. . . " (p. 130) to become Inspector-General of hospitals for the British Army. "Dr. Barry died in London in 1865, and was found on post-mortem to have been a woman. The War Office and the British Medical Association must have been dumbfounded." (p. 277)

In the early half of the nineteenth century the feminist trend was closely associated with the education of women and with humanitarian projects including medical service, which implied medical education. Preliminary work was carried on by individuals in different parts of the United States. In 1848 the first woman's rights convention was held at Seneca Falls, N.Y., and in 1849 the first woman to receive a medical degree in the United States was graduated at Geneva. Quakers participated in these significant events. In 1850 the first national woman's rights convention was held at Worcester, Mass., and that same year the Female Medical Education Society was incorporated at Boston and the medical school for women was opened at Philadelphia. Meanwhile, eight women had been matriculated by the Central Medical College of New York at Syracuse, one of whom was graduated in 1850, and beyond the Alleghenies a woman was admitted to the Cleveland Medical College, which afterward became the Medical Department of the Western Reserve University.

". . . the first three women with diplomas from legally authorized medical schools to practice medicine in Great Britain, the United States, and Canada were graduates of three small institutions in the state of New York. . . . These women—Elizabeth Blackwell, an Englishwoman, Lydia Folger Fowler, an American, and Emily Jennings Stowe, a Canadian—wanted to be good doctors. As alma maters, they would have preferred Oxford, Harvard, and McGill—but they had to take what they could get." (p. 119)

The first woman to be graduated as a doctor was Elizabeth Blackwell, who was admitted to Geneva Medical College in 1847 and who was graduated in 1849, the head of her class. Her influence continues to be strongly felt today, and annually in the springtime the Elizabeth Blackwell Award is given to the outstanding women physicians of the year (see page 188). Although Elizabeth Blackwell was the first woman to be graduated as a doctor, it was her younger sister, Emily, who remained in the United States and worked so long and lovingly founding and maintaining the New York Infirmary, which not only has cared for generations of New Yorkers but which for many years was instrumental in educating women in medicine.

The second half of the nineteenth century was truly the turning point for women desiring careers, and Dr. Lovejoy with meticulous research traces the beginnings in Europe and later in Asia.

What makes this book so remarkable is that the woman writing it has had an influential part

in the story she tells. Born in Washington territory, she herself established a series of "firsts." Although, as she points out, she was the second woman to be graduated from the University of Oregon College of Medicine, she was the first woman graduate to use her education. Despite an active practice she joined the Portland Health Department and became the only woman ever to be at its head. She brought her special talents as a woman and a mother to her duties, introducing school inspection (using colleague volunteers), writing the first milk ordinance passed by the city council, and co-operating with women's organizations in measures for the promotion of public health.

Although women were well recognized by the time of the first World War as licensed physicians, they were still not complete in their participation as citizens. They could not vote in all the states, and in wartime their services were not acceptable to the armed forces. A war service committee was appointed by the President of the Medical Women's National Association, and its representative, Dr. Lovejoy, went to France, where she joined the American Red Cross. The work of American women doctors in France during the first World War and early reconstruction years was vividly described in her book "Certain Samaritans" and is summarized in "Women Doctors of the World," along with the activities of medical women of other countries. On returning in 1919 she was appointed Chairman of the American Women's Hospitals Committee of the American Medical Women's Association, which conducts a medical relief service in various parts of the world.

> "This book is a thanks offering. Near the end of a long life I am thankful for the opportunities and for the friends in the field of medicine in which it has been my privilege to serve . . . .
>
> "The office of the American Women's Hospitals in New York City was the headquarters of the Medical Women's International Association during its formative years while I was President, and the headquarters of the American Medical Women's Association from 1919 to 1950. Articles and books by women doctors as well as official publications of medical societies passed over my desk in this office, which became a center of information about women in medicine." (preface, VII)

Who could better or more accurately write a book on "Women Doctors of the World?" We can be most thankful that in addition to her other duties Dr. Lovejoy took up this task in her ninth decade. Not only is the information meticulously accurate and well documented but her wealth of information is presented in a lively, readable style. To read this book is like knowing the author—a great privilege and rare treat for which one can only be profoundly grateful.

—Margaret Schaffner Tenbrinck, M.D.

Books Received

The following books have been received for review, and are recommended to our readers.

A QUEST INTO THE ENVIRONMENTAL CAUSES OF CANCER OF THE LUNG. By W. C. Hueper, M.D., Head of the Environmental Cancer Section, National Cancer Institute. Public Health Monograph No. 36. Pp. 54. Price $0.45. Government Printing Office, Washington 25, D.C., 1955.

THE OFFICE ASSISTANT in Medical and Dental Practice. By Portia M. Frederick, Instructor, Medical Office Assisting, Long Beach City College, and Carol Towner, Executive Assistant, Department of Public Relations, American Medical Association. Pp. 351, with 55 figures. Price $4.75. W. B. Saunders Company, Philadelphia, 1956.

JOINT FAO/WHO EXPERT COMMITTEE ON MEAT HYGIENE, First Report. World Health Organization Technical Report Series No. 99. Pp. 52. Price $0.60. World Health Organization, Geneva, Switzerland, 1955.

AMPUTEES AND PROSTHESES; Report of a Conference on Prosthetics. World Health Organization Technical Report Series No. 100. Pp. 52. Price $0.60. World Health Organization, Geneva, Switzerland, 1955.

POLIOMYELITIS VACCINATION; A Preliminary Review. World Health Organization Technical Report Series No. 101. Pp. 40. Price $0.30. World Health Organization, Geneva, Switzerland, 1956.

NEW AND NONOFFICIAL REMEDIES 1956. Council on Pharmacy and Chemistry of the American Medical Association. Pp. 540. Price $3.35. J. B. Lippincott Company, Philadelphia, 1956.

CORRECTION

In the section on Book Notices of March, 1957, page 93, a review of the book, "Basic Principles of Parliamentary Law and Protocol," by Marguerite Grumme, R.P., listed her address incorrectly. The correct address from which this book can be obtained is 3830 Humphrey St., St. Louis 16, Mo.

Book Notices

Editor's Note: These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.

PATHOLOGY SEMINARS. By Lauren V. Ackerman, M.D., F.A.C.P., Arthur C. Allen, M.D., Arthur Purdy Stout, M.D., Col. J. E. Ash, M.D., F.C.A.P., and Rupert A. Willis, M.D., F.R.C.P. Edited by Robert S. Houkohl, M.S., M.D., F.C.A.P., Assistant Professor of Pathology, Marquette University School of Medicine, and W. A. D. Anderson, M.A., M.D., F.C.A.P., F.A.C.P., Professor of Pathology and Chairman of the Department of Pathology, University of Miami School of Medicine. Pp. 195, with 131 figures. Price $10.00. C. V. Mosby Company, St. Louis, 1955.

This book contains three seminars, in each of which ten to fifteen tumors of various sites are presented. They appear to have been selected for difficulty of diagnosis, as is usual in the case of seminars. Microphotographs are fair; references are listed.

The seminar on the Pathology of the Skin is excellent for general pathologists. Gross and microscopic illustrations are good.

In the seminar entitled Tumors of the Nose and Throat, inflammatory lesions are also presented.

The index is good, and particularly useful in a book of this type.

—Mollie A. Geiss, M.D.

TEXTBOOK OF MEDICAL PHYSIOLOGY. By Arthur C. Guyton, M.D., Professor and Chairman of the Department of Physiology and Biophysics, University of Mississippi School of Medicine. Pp. 1,033, with 577 figures. Price $13.50. W. B. Saunders Company, Philadelphia, 1956.

This new physiology textbook is a welcome addition and should be of great benefit to the medical student, for whom it was written expressly.

In the preface, Guyton has defined physiology as including abnormal as well as normal physiology and he presents both in his book, "to provide the student with that transitional information which he needs to apply physiologic principles in other medical studies." He does this successfully by keeping presentation and explanation simple and clear.

The content of the book is comprehensive, and it is written in a very readable style. In a few instances a poor choice of words gives a false impression unless the reader is familiar enough with the subject to understand what is meant.

There are over 600 schematic line drawings to assist in clarification of the text. These are well done and add greatly to the book. The bibliographies at the end of each chapter are extensive and up-to-date.

—Mary P. Wiedman, Ph.D.

TECHNIQUES AND PROCEDURES OF ANESTHESIA. By John Adriani, M.D., Director, Department of Anesthesia, Charity Hospital, Professor of Surgery, School of Medicine, Tulane University of Louisiana, and Clinical Professor of Surgery and Pharmacology, School of Medicine, Louisiana State University, New Orleans, Louisiana. Second Edition. Pp. 568, illustrated. Price $8.95. Charles C Thomas, Springfield, Ill., 1956.

The second edition of this book is almost a completely new book. The author has retained his usual fine method of presenting the subjects in more or less outline form. He covers the subject of anesthesia from every possible angle, including the preoperative and preanesthetic period and the postoperative recovery period. The novice, as well as the expert in anesthesia, will find this a quick and reliable reference for all kinds of problems of anesthesia.

The section on nerve blocks is quite adequate for everyday use. Presentation is such as to make nerve blocks appear to be comparatively simple procedures.

Resuscitation and inhalation therapy, two problems that are getting more and more attention, which they justly deserve because of their importance, are also included in this book. All in all, this volume will be the one most frequently used by both the anesthesiologist and the occasional anesthetist.

—Richard R. Lamb, M.D.

BLAKISTON'S NEW GOULD MEDICAL DICTIONARY. Second Edition. Edited by Normand L. Hoerr, M.D., and Arthur Osol, Ph.D., with the co-operation of an Editorial Board and Eighty-Eight Contributors. Pp. 1,463, with 252 illustrations on 45 plates, 129 in color. Price $11.50, McGraw Hill Book Company, Blakiston Division, New York, 1956.

Many new words and terms have been introduced into medical literature during the seven years since the printing of the first edition of this dictionary. The editors of this second edition served in the same capacity for the 1949 printing and have used the same format throughout in the present volume. The size of this edition is increased by only 169 pages despite the fact that 1,200 new terms have been added and 8,000 changes within definitions have been made. Among the useful new inclusions in this volume is a table of radioactive isotopes used investigatively and therapeutically. With all the new entries, it is difficult to see how some of the newer drugs coming into common usage were omitted. Nystatin and Novobiocin are not mentioned by either their generic or trademark names. Likewise in the listing of viral diseases, APC disease receives no mention. Properly chosen deletions of obsolete and valueless terms do not in any way detract from the value of the dictionary.

Although there may be minor criticisms, this modernized revision gives us an excellent medical dictionary, which should be available for everyone interested in any category of medical work.

—George A. Hess, M.D.

THE RECOVERY ROOM—Immediate Postoperative Management. By Max S. Sadove, M.D., and James H. Cross, M.D. With contributions by 24 authorities. Pp. 565, illustrated. Price $12.00. W. B. Saunders Company, Philadelphia, 1956.

This is a timely and valuable contribution, filling a long-felt need in the field of planning and function of a recovery room as well as medical and surgical care of the patient in the immediate postoperative period. Results of the study of the advantages of a recovery room and its intensive therapy unit are shown: increased efficency of care for all postoperative patients; less morbidity and mortality; conservation and concentration of technical skills; more effective utilization of personnel, equipment, and supplies; and the advantages of team physician care and continuous skilled special nursing care. The physician is assured of careful supervision for his patients and the knowledge that his orders will be carried out completely.

Plans for location, space, physical features, records, personnel, transportation, laboratory, and kitchen are discussed in detail. Routine procedures and examinations of patients, as well as final examination before discharge, are given.

The chapters on shock, respiration, and nutrition afford a valuable review of these subjects. Preoperative and postoperative care in all disciplines of surgery, all postoperative complications, and management of medical problems receive careful consideration. The final chapter pays special attention to nursing care in the recovery room.

Since this is a comparatively new factor in postoperative care it should be of great value to physicians and hospital personnel alike.

—L. E. Kazainis, M.D.

SYNOPSIS OF GYNECOLOGY. By Robert James Crossen, M.D., F.A.C.S., Associate Professor of Clinical Gynecology and Obstetrics, Washington School of Medicine. Fourth Edition. Pp. 245, with 132 illustrations. Price $5.25. The C. V. Mosby Company, St. Louis, 1956.

This book, a brief review of all gynecologic conditions, deals with the anatomy and physiology of the reproductive organs. Diagnostically, it gives the salient features pertaining to all the diseases in this field. It mentions the type of treatment and at times is specific about medical treatment; but for most surgical treatment the reader is referred to a more detailed textbook. In the few instances in which any surgical procedure is described, it is too inadequate to be of much use and would probably best have been deleted. It is intended primarily as a review for students who are about to take examinations or for doctors in other branches of medicine who desire a quick review on the subject to keep well rounded in the general field of medicine. For this purpose it is to be recommended.

—Elise Renning, M.D.

ESSENTIALS OF HISTOLOGY. By Margaret M. Hoskins, Ph.D., and Gerrit Bevelander, Ph.D., School of Dentistry, New York University. Third Edition. Pp. 254 with 146 illustrations, 2 color plates. Price $4.00. C. V. Mosby Company, St. Louis, 1956.

The authors of this small book have succeeded in affording the student of microscopic anatomy with an opportunity to familiarize himself with, or to make a rapid review of, the essential morphologic characteristics of tissues and organs. The material is necessarily condensed but the readability of the text does not suffer from this fact. In certain instances, the authors fail to present the most recent and generally accepted concepts of cytology and histology, for exampde, in their discussion of cell organoids and in their description of the liver parenchyma. The text figures are instructive and adequate in number and, for the most part, in quality. Although the inclusion of an extensive bibliography is understandably beyond the scope of this volume, it would seem proper and helpful to have included a list of standard textbooks in the field of microscopic anatomy for reference.

—E. Frances Stilwell, Ph.D.

PROCTOLOGY. By Harry E. Bacon, M.D., ScD., L.L.D., F.R.S.M. (Lond.), F.A.C.S., F.I.C.S. (Hon.), F.P.C.S, Professor and Head, Department Proctology, Temple University Medical School, Diplomate American Board Surgery, President-Elect, American Board Proctology; Stuart T. Ross, NM.D., F.A.C.S., F.A.P.S., F.I.C.S., Attending Proctologist, Nassau Hospital, Mineola, Mercy Hospital, Rockville Centre, President, American Proctologic Society, Diplomate and Secretary, American Board of Proctology; and Porfirio Mayo Recio, M.D., M.Sc., F.P.C.S., F.I.C.S., Assistant Professor Surgery, College of Medicine, University of Philippines, Attending Proctologic Surgeon, Philippine General Hospital, Diplomate, American Board Proctology, Regent, Philippine College Surgeons. Pp. 441, with 228 illustrations and 5 plates in full color. Price $10.00. J. B. Lippincott Company, Philadelphia and Montreal, Canada, 1956.

The title is rather inclusive, but falls short of describing the completeness of the subjects covered in this volume. The authors have ably presented in 30 chapters a comprehensive, well-written, and readable textbook that should be valued by a beginning student and enjoyed by the mature practitioner. The authors have kept in mind simplicity and lucidity in presenting facts.

The essential facts of this book concern the surgical diseases of the anal canal, rectum, and colon. Throughout the book are incorporated recently developed methods of the preoperative and postoperative management of surgical patients, with consideration for the relief of postoperative pain. In each subject presented, such as hemorrhoids, pruritus ani, anorectal abscess, fistula, and so forth, emphasis is placed on diagnosis and treatment, with a clear description of the anatomy and pathology. The subjects are well illustrated, and a complete descriptive analysis is given of the minor and complicated operations.

Treatment with newer facilities, antibiotics, antiseptics, sedatives, and anesthesia, in hospital care, is covered. Office procedure as performed by the physician and instruction to the patient for personal administrations at home are treated fully. The chapters on granuloma inguinale and chancroid contain new material, and a detailed discussion in the chapter on diverticulosis and diverticulitis and volvulus is given. The new surgical techniques presented in the treatment of prolapse and procidentia, and the attention given to the problem of incontinence, make worthwhile reading.

In the final chapter, Dr. Samuel W. Eisenberg discusses thoroughly the effects of parasitic diseases in the lower intestinal tract.

The book has an abundance of descriptive illustrations and is well indexed. It is printed clearly on glossy paper and is recommended to specialists, general practitioners, and medical students.

—Frank H. Murray, M.D., F.A.C.S.

EDITORIAL FORECAST

July 1957

The July number of the JOURNAL will be the annual World Health Organization issue. Articles have been written especially for the JOURNAL by staff members of WHO.

"The Effect of Radiation on Human Heredity," by Ivor S. Eve, M.B., M.R.C.P.

"The Fight Against Nonvenereal Treponematoses in Africa," by F. S. da Cruz Ferreira, M.D., D.T.M.

"Malaria Eradication as a World Program," by E. B. Weeks, M.D.

"The Family Doctor's Tasks and Opportunities in the Field of Mental Hygiene," by E. E. Krapf, M.D.

"The First Public Health College and Training Center in Ethiopia: Gondar College," by A. T. Shousha, M.D.

"Fellowships, A Part of the Education and Training Program of WHO," by D. A. Messinezy, M.D., M.P.H.

A summary of WHO activities for 1956 will be included, as well as a special book review of "Discussions on Child Development," prepared by Margaret S. Tenbrinck, M.D.

This number will also include the Inaugural Address — Sedatives, Tranquilizers — Then What? — of the new AMWA President, Elizabeth S. Kahler, M.D., and a biographical sketch of her life.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

APPLICATION FOR MEMBERSHIP

Name ..... Date ....
(Please print as it should appear in the Directory.)

Address (Present) .....

Address (Permanent) .....
(Please check address to which JOURNAL and AMWA correspondence are to be mailed.)

Medical School .....Year of Graduation .....

Licensed in County .....State .....

Specialty .....Certification by American Board of.....Year....

Date and Place of Birth .....

Medical Society Affiliations .....

.....

.....

Hospital and Faculty Appointments .....

.....

Public Health, Government, or Industrial Appointments .....

.....

.....

Check membership desired:

☐ Life-Dues $200 (May be paid in two installments in two consecutive years).

☐ Active-Dues $10 per annum. (Branch dues not included in Active membership dues and are payable to Branch treasurer.)

☐ Associate-No dues. ☐ Junior-No dues.

Medical Women's International Association

President: Dr. M. Yolanda Tosoni Dalai, 1, via Giustiniano, Milan, Italy.

Past President: Dr. Ada Chree Reid, 118 Riverside Drive, New York, U.S.A.

Hon. Treasurer: Dr. H. de Roever-Bonnet, J. van Eyckstraat 8, Amsterdam, Holland.

Hon. Secretary: Dr. Janet K. Aitken, Acacia House, 30a Acacia Road, Regent's Park, London, England.

Vice-Presidents: Prof. Marie L. Chevrel, 14, rue des Fossees, Rennes, I. et V., France.

Dr. Inger Haldorsen, Rikard Nordraksgtn 4, Bergen, Norway.

Dr. Anna Jacob-Peller, 23 Mazastr, Tel-Aviv, Israel.

Dr. Fe del Mundo, 34 Kitanlad, Quezon City, Manila, Philippines.

Dr. Anna Walthard-Schaetti, Eierbrechstr. 71, Zurich 7, Switzerland.

Dr. Marion Hilliard, 716, Medical Arts Bldg., Toronto, Canada.

AMWA International Corresponding Secretary:

Alma Dea Morani, M.D., 3665 Midvale Ave., Philadelphia, Pa.

CONSTITUTION OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

Article III. Section 1a. **Active Members** "shall be members of a Branch, if any local Branch exists; if not, they may be Members-at-large."

Article III. Section 6. **Associate Members** "shall be: (1) Medical women in the first year of practice; (2) women interns, residents-in-training, and fellows. Associate members shall not pay dues and shall have all privileges of memberships, except voting, holding office, and membership in the Medical Women's International Association."

Article III. Section 7. **Junior Members** "shall be members of Junior Branches in the four undergraduate years of medical school."

All members receive the official publication, the Journal of the American Medical Women's Association. Life and Active members receive membership in the Medical Women's International Association.

Signature.....

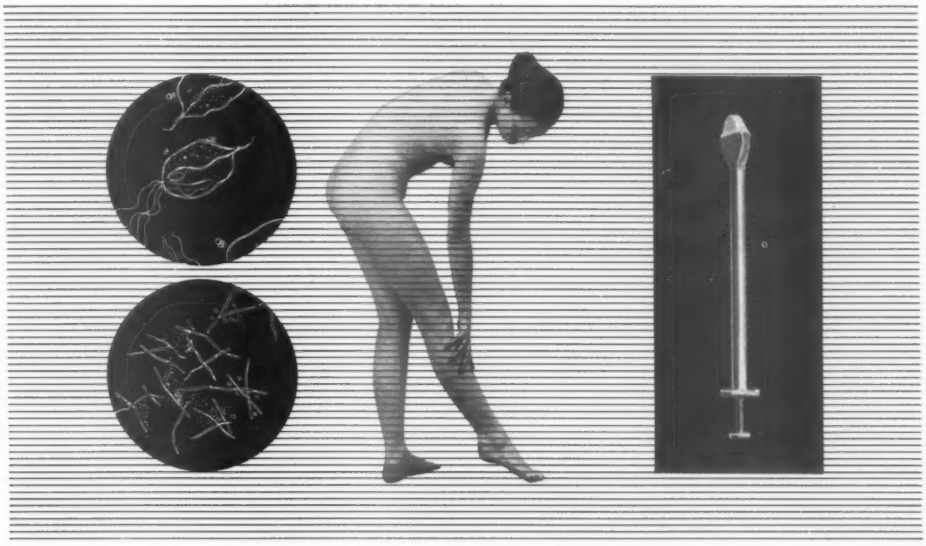
Endorsers are required only if applicant is NOT a member of a State or County medical society. Endorsers must be members of American Medical Women's Association.

Endorser: 1. ..... Address.....

2. ..... Address.....

Checks payable to the American Medical Women's Association, Inc. must accompany application. Mail to Treasurer, A.M.W.A., 1790 Broadway, Room 409, New York 19, New York, or to Branch Treasurer.

FOR FLAGELLATE AND FUNGAL VAGINITIS



Floraquin®

Destroys Common Vaginal Pathogens; Rebuilds Normal Bacterial Barrier

Whenever a woman complains of vaginal discharge with pruritus, a trichomonal infection[1] must be suspected. Moniliasis, the second most frequent cause[2] of leukorrhea, often occurs[3] in conjunction with diabetes mellitus, pregnancy and estrogen or broad spectrum antibiotic therapy. Commonly used douches wash away normal acid secretions and protective Döderlein bacilli, thus tending to aggravate the problem.

Floraquin, containing Diodoquin® (diiodohydroxyquin, U.S.P.), eliminates infection and provides boric acid and sugar to restore the acidic pH which favors replacement of pathogens by normal Döderlein bacilli. The danger of recurrence is thus minimized.

Pitt reports[2] consistently good results after daily vaginal insufflation of Floraquin powder for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles.

Intravaginal Applicator for Improved Treatment of Vaginitis—

This smooth, unbreakable, plastic plunger device is designed for simplified insertion of Floraquin tablets by the patient; it places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. A Floraquin applicator is supplied with each box of 50 tablets.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

---

1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157*:126 (Jan. 8) 1955.

2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25*:182 (Feb.) 1956.

3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51*:1494 (June 15) 1956.

SEARLE

A brighter outlook comes with a "sense of well-being"

Every woman who suffers in the menopause deserves "Premarin."

"Premarin" provides prompt relief from distressing symptoms and an added "sense of well-being."

"Premarin," available as tablets and liquid, presents the complete equine estrogen-complex. Has no odor, imparts no odor.

"PREMARIN"®
Conjugated estrogens (equine)

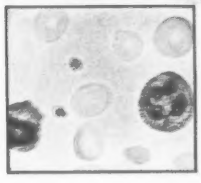
in the menopause and
the pre-and postmenopausal syndrome

Ayerst LABORATORIES • New York, N. Y. • Montreal, Canada

5643

IN IRON-DEFICIENCY ANEMIA
IN NUTRITIONAL ANEMIA

potent antianemia therapy plus basic nutritional support



filmtab® Iberol® IS IRON PLUS

2 IBEROL Filmtabs a day supply:

THE RIGHT AMOUNT OF IRON
Ferrous Sulfate, U.S.P.....1.05 Gm.
(Elemental Iron—210 mg.)

PLUS THE COMPLETE B COMPLEX
BEVIDORAL®.....1 U.S.P. Unit (Oral)
(Vitamin B_{12} with Intrinsic Factor Concentrate, Abbott)
Folic Acid .....2 mg.

Liver Fraction 2, N.F.....200 mg.
Thiamine Mononitrate .....6 mg.
Riboflavin.....6 mg.
Nicotinamide.....30 mg.
Pyridoxine Hydrochloride.....3 mg.
Calcium Pantothenate.....6 mg.

PLUS VITAMIN C
Ascorbic Acid .....150 mg.

*06162

Abbott

NO WITHDRAWAL BLEEDING

Vallestril® relieved symptoms in 91 per cent of menopausal patients

Physicians are aware of the anxiety caused when bleeding occurs during menopausal therapy. According to Goldfarb and Napp, "for this reason, as well as the possibility of masking carcinoma, the great advantage of methallenestril [Vallestril] lies in the absence of bleeding during therapy or on discontinuance of treatment with this drug."*

Attending this unique therapeutic advantage, these investigators observed that relief of symptoms with Vallestril occurred in 91 per cent of 100 menopausal patients.

Administration—For the menopausal syndrome two 3-mg. tablets (6 mg.) of Vallestril should be taken daily for three weeks; thereafter, to control symptoms 3 mg. daily for as long as required. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

*Goldfarb, A. F., and Napp, E. E.: Use of Methallenestril (Vallestril) in Control of Menopausal Symptoms, J.A.M.A. *161*:616 (June 16) 1956.

SEARLE

Coca-Cola . . . Favorite of the World. ***A famous Canadian resort inspires another interpretation from the talented brush of Jack Potter.***

"COKE" IS A REGISTERED TRADE-MARK. COPYRIGHT 1952 THE COCA-COLA COMPANY

AT LAKE LOUISE, TOO . . . "SIGN OF GOOD TASTE" . . . The instinct for pleasant living goes wherever pleasant people go . . . and takes the custom of enjoying Coca-Cola with it. So good in taste, in such good taste . . . in more than 100 countries today, *Have a Coke* is the recognized invitation to one of life's unique pleasures.

Coca-Cola

REG. U.S. PAT. OFF.

SIGN OF GOOD TASTE

INDEX TO ADVERTISERS

Abbott Laboratories 15, 37
Ayerst Laboratories 36
Bristol-Myers Company 24
Ciba 1
Coca-Cola 39
Esta Medical Laboratories 42
Hoffmann-La Roche, Inc. ..... (16-17), 29
Holland-Rantos Company, Inc. 22
Johnson & Johnson 9, 10
Lederle Laboratories 13, 30-31
Eli Lilly & Company 32
The S. E. Massengill Company 23
Mead Johnson ..... Back Cover, 19, 41
Merck Sharp & Dohme .... Inside Back Cover, 11
Ortho Laboratories 25
Parke, Davis & Company 14, 21
Pfizer Laboratories 5, 17
Riker Laboratories ..... Inside Front Cover, 2
J. B. Roerig & Company 16
Schering Corporation 7
G. D. Searle & Company 20, 35, 38
Tampax Incorporated 28
Wyeth Laboratories 27

INDEX TO PRODUCTS ADVERTISED

Analgesics
Nupercaine *(Ciba)* 1

Anorexigenic Agents
Altepose *(Merck Sharp & Dohme)* ..... Inside Back Cover
Obedrin *(Massengill)* 23

Antacids
Sal Hepatica *(Bristol-Myers)* 24

Antibiotics
Achromycin V *(Lederle)* 30-31
Matromycin *(Pfizer)* 5

Antiemetics
Bonadoxin *(Roerig)* 16
Dramamine *(Searle)* 20

Antihistamine
Co-Pyronil *(Lilly)* 32

Antiprurients
Meti-Derm *(Schering)* 7
Tashan Cream *(Hoffmann-La Roche)* .. (16-17)

Baby Products
Baby Lotion *(Johnson & Johnson)* 9
S-M-A- Instant Powder *(Wyeth)* 27

Contraceptives
Lanteen *(Esta)* 42
Delfen *(Ortho)* 25

Coronary Vasodilator
Pentoxylon *(Riker)* ..... Inside Front Cover

Dietary Supplements
Deca-Mulcin *(Mead Johnson)* 19
Deca-Vi-Caps *(Mead Johnson)* 19
Deca-Vi-Sol *(Mead Johnson)* 41
Poly-Vi-Sol *(Mead Johnson)* 41
Redisol *(Merck Sharp & Dohme)* 11
Sur-Bex with C *(Abbott)* 15
Tri-Vi-Sol *(Mead Johnson)* 41
Vi-Penta *(Hoffmann-La Roche)* 29

—Prenatal
Obedrin *(Massengill)* 23
Prenatal Dri-Kaps *(Lederle)* 13
Storcavite *(Roerig)* 16

Hematinic
Iberol *(Abbott)* 37

Hormones
Menagen *(Parke, Davis)* 14
Premarin *(Ayerst)* 36
Theelin R-P *(Parke, Davis)* 21
Vallestril *(Searle)* 38

Laxatives
Colace *(Mead Johnson)* ..... Back Cover
Peri-Colace *(Mead Johnson)* ..... Back Cover

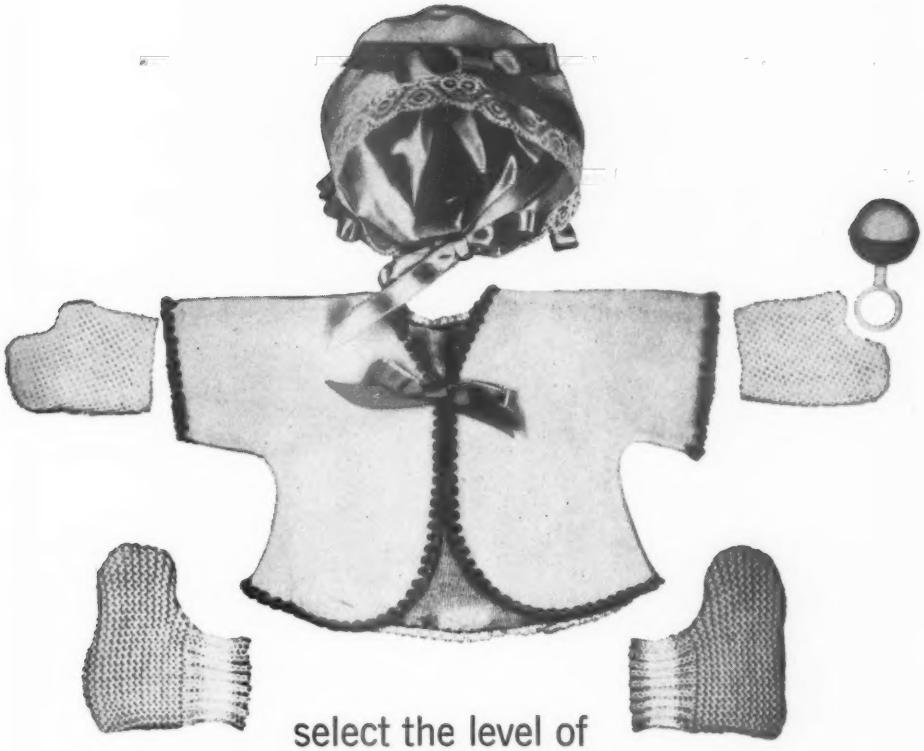
Medicated Powder
Medicated Powder *(Johnson & Johnson)* 10

Nebulizer
Medihaler *(Riker)* 2

Steroids
Meti-Derm *(Schering)* 7
Sterane *(Pfizer)* 17

Tampons
Tampax *(Tampax)* 28

Vaginal Therapeutics
Floraquin *(Searle)* 35
Nylmerate *(Holland-Rantos)* 22



select the level of

vitamin protection the baby needs

Tri-Vi-Sol®

3 basic vitamins...A, D, C

Poly-Vi-Sol®

6 essential vitamins...A, D, C, B_1, B_2 and niacinamide

Deca-Vi-Sol®

10 nutritionally significant vitamins, including A, D, C, B_1, B_2, niacinamide, biotin, pantothenic acid, B_6 and stable B_{12}

unbreakable "Safti-Dropper"

- highly stable—refrigeration not required
- readily accepted—exceptionally pleasant flavor, no unpleasant aftertaste
- full dosage assured—can be dropped directly into baby's mouth

In 15 cc., 30 cc. and economical 50 cc. bottles with calibrated plastic 'Safti-Dropper'

13557

MEAD JOHNSON

SYMBOL OF SERVICE IN MEDICINE

Naturally she'll appreciate efficacy with elegance

LANTEEN® EXQUISET*

for natural acceptance of your prescribed contraceptive regimen • fulfills your patient's natural wish that her possessions reflect her femininity. Each Lanteen Exquiset contains: 3 oz. tube of Lanteen spermicidal jelly, soothing, cleanly scented; easy-to-insert, molded, flat spring diaphragm; ***Easy-Clean*** applicator; universal inserter—all fitted into a stylish, soft plastic purse.

Lanteen jelly contains ricinoleic acid 0.50%, hexylresorcinol 0.10%, chlorothymol 0.0077%, sodium benzoate and glycerin in a tragacanth base. Lanteen jelly and flat-spring diaphragm sets are distributed by George A. Breon & Company, 1450 Broadway, New York 18, N.Y. (In Canada: E. & A. Martin Research Ltd., 20 Ripley Ave., Toronto, Canada.) Manufactured by Esta Medical Laboratories, Inc., Chicago 38, Ill.

*Trademark of George A. Breon & Company

A little weight loss adds a lot to life

ALTEPOSE®

Hunger is a powerful distracting force, hard to ignore. When your fat patient's will power needs a prop, ALTEPOSE can help. The 'Propadrine' in ALTEPOSE curbs the appetite with less central nervous stimulation than amphetamine. Thyroid releases tissue-bound water, thus brings about encouraging weight loss early in the diet regimen. 'Delvinal' relieves tension and irritability.

MSD

MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

in your management of constipation

when bowel motility is inadequate, prescribe

new Peri-Colace | Capsules, Syrup

peristaltic stimulant – stool softener, Mead Johnson

softens stools and stimulates peristalsis

when bowel motility is adequate, prescribe

Colace | Capsules, Syrup, Liquid (drops)

dioctyl sodium sulfosuccinate, Mead Johnson

softens stools for easy passage

COLACE PRODUCTS FAMILY

New Peri-Colace · Capsules · Syrup

Colace Capsules · Liquid · Syrup

35757

MEAD JOHNSON

SYMBOL OF SERVICE IN MEDICINE